Statewide Educational Wrap Up Program (SEWUP) JPA
Owner Controlled Insurance Program (OCIP)

Project Insurance Manual

www.sewup.org

Program Administrator:

Keenan

2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501
Phone: 800.654.8102
SEWUP Department
Fax: 310.787.8838
License # 0451271
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<td>38</td>
</tr>
</tbody>
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Preface

About This Manual

- Identifies responsibilities of the various parties involved in the project
- Provides a basic description of the OCIP coverage and program structure
- Describes audit and administrative procedures
- Provides answers to basic questions about the OCIP
- Claim reporting procedures
- Will be updated as necessary

This Manual Does Not

- Provide OCIP coverage interpretations
- Provide complete information about OCIP coverages (Refer to OCIP policies)
- Provide answers to specific claims questions
1.0 Introduction

The Statewide Educational Wrap Up Program JPA (SEWUP), of which this school district is a member, is providing an Owner Controlled Insurance Program for work performed at specific project sites, on behalf of the district, who is the “Owner”.

The OCIP provides the following insurance for all eligible and enrolled contractors, providing direct labor, regardless of tier, that are approved for participation in the OCIP.

- Workers’ Compensation & Employers Liability
- Commercial General Liability & Excess Liability
- Builder’s Risk
- Contractor’s Pollution Liability

Note

The guidelines in this manual are to be used for informational purposes only. This manual does not constitute a contractual agreement. If conflicts exist between this manual and OCIP Insurance Policies, or this manual and the Contract between the District, Construction Manager, and Contractor (Enrolled Parties), OCIP Policies or Owner’s Contract will govern.

1.1 Contractor Eligibility

Eligible Contractor includes all Contractors/Subcontractors providing direct labor on the Project. Temporary labor services and leasing companies are to be treated as Eligible Contractors.

Ineligible Contractor includes, but is not limited to, consultants; suppliers who do not perform or do not subcontract installation; abatement and/or removal of hazardous materials; vendors; materials dealers; surveyors; consultants; guard services; non-construction janitorial services; and truckers, including trucking to the Project where delivery is the only scope of work performed. It is not the intent of this wrap-up to include any such entities. However, if contracted with an on-site installer, suppliers/vendors should be enrolled in the OCIP only for General Liability, as it pertains to the contractual relationship of the installer’s on-site work. Ineligible contractors will be required to adhere to insurance certificate requirements as stated in section 4.3, under Contractor-Provided Insurance Coverage. In addition, any party deemed an Ineligible Contractor, but who has direct labor on the Project, will be required to participate in the Project Safety Program (see Section 5).

Any questions regarding a Contractor’s status as “Eligible” or “Ineligible” should be referred by written request to Owner.

1.2 Participation

Participation in the OCIP is mandatory but not automatic. Each Eligible Contractor must follow the enrollment requirements, as specified in Section 4.
Enrollment (Definition): An Eligible contractor is not enrolled until the Program Administrator receives and approves a completed Contract Enrollment Form, for each awarded contract, prior to commencement of on-site activities. Evidence of Insurance for work performed off-site is a requirement, as specified in Section 4.3. These documents must be submitted with the completed Contract Enrollment Form.

1.3 Project Site and Offsite Premises

Coverages provided by the OCIP are Project Site specific. The Project-Site must be designated by the Owner. The Project Site consists of any and all projects that are endorsed to this policy, which includes the:

- Ways and means adjoining the endorsed project site.
- Adjacent locations to the endorsed projects sites where incidental operations are being performed, excluding permanent locations.

With the exception of 1 and 2 mentioned above, off-site locations, labor and operations are not covered by the OCIP. It will be the responsibility of each contractor to maintain off-site insurance, as identified in Section 4.3, which specifies coverage types and minimum limits. Contractor will promptly furnish to the Owner, or their designated representative, Certificates of Insurance evidencing that all required insurance is in force.

2.0 Information Directory

2.1 Program Administrator

Keenan & Associates - SEWUP Department
2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501
Phone: 800.654.8102
Fax: 310.787.8838

Questions Regarding OCIP

Refer questions concerning the OCIP, its administration or coverages to the Program Administrator. There are answers to frequently asked questions in Section 8 of this manual.

2.2 Insurance Companies

Workers’ Compensation  Arch Insurance Company
General Liability    Arch Insurance Company
Excess Liability     Axis Surplus Insurance Company
Builder’s Risk       Ace American Insurance Company
Contractor’s Pollution Liability Arch Specialty Insurance Company

Emergency: 911
3.0 OCIP Coverages

Description of Owner Controlled Insurance Program (OCIP) Coverages

The OCIP is for the benefit of the Owner and all Enrolled Contractor/Subcontractors who have on-site employees. OCIP coverage applies only to Work performed under the contract at the Project Site specified by the Owner. All Contractors must provide their own insurance for Automobile Liability and off-site locations, labor, and operations. The following coverages are provided by the OCIP:

- Workers’ Compensation and Employers Liability
- Commercial General & Excess Liability
- Builder’s Risk
- Contractor’s Pollution Liability

OCIP Disclaimer

The OCIP is intended to provide broad coverages and high limits, to all Enrolled Contractors/Subcontractors. The Owner does not warrant or represent that the OCIP coverages constitute an insurance program that completely addresses the risks of the Contractors/Subcontractors. Prior to contract award, it is the responsibility of all Contractors/Subcontractors to ensure that the OCIP coverages provided sufficiently address their insurance needs. Upon request, OCIP policies are available for review.

3.1 Workers’ Compensation and Employer’s Liability Insurance

All Enrolled Contractors/Subcontractors will receive their own Workers’ Compensation policy.

Coverage A – Workers’ Compensation

Liability imposed by the Workers’ Compensation and/or Occupational Disease statute of the State of California or governmental authority having jurisdiction related to the work performed on the Project.

Coverage B – Employers Liability

$1,000,000 Bodily Injury each Accident
$1,000,000 Bodily Injury by Disease – Policy Limit
$1,000,000 Bodily Injury by Disease – Each Employee
Contractor Deductible: None

3.2 Commercial General Liability & Excess Liability Insurance

All Enrolled Contractors/Subcontractors are considered Named Insured under SEWUP’s Master General & Excess Liability policies. The Master Policies are available for review by Contractors/Subcontractors, upon request to the Owner or the Program Administrator.

**Primary Coverage: Total Limits for Bodily Injury and Property Damage**

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each Occurrence</td>
<td>$8,000,000</td>
</tr>
<tr>
<td>General Annual Aggregate – per Project</td>
<td>$11,000,000</td>
</tr>
<tr>
<td>Products and Completed Operations Aggregate</td>
<td>$11,000,000</td>
</tr>
</tbody>
</table>

Policy Forms: “Occurrence” Form

Contractor Deductible: None

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Note:

(1) This insurance does not provide coverage for products liability of any enrolled party for any product manufactured, assembled or otherwise worked upon away from the Project Site.

(2) Products and Completed Operations Aggregate is not reinstated annually and is effective for ten (10) years after Notice of Completion is filed by the Owner, or date Occupancy is taken.

---

3.3 Builder’s Risk Insurance

Master policy names the Owner as the “Named Insured” and the Contractors/Subcontractors enrolled in the OCIP will be named “Additional Named Insured”. This Master policy is available for review by Contractors/Subcontractors, upon request to the Owner or the Program Administrator.

**Primary Coverage**

The policy covers materials, supplies, equipment, fixtures, or machinery, which will become a permanent part of the building, or structure at the Project site specified, limited to policy form, policy limit, and exclusions.

**Deductible**

A deductible, which shall be determined by the type of construction, will apply to each occurrence. The deductible schedule is as follows:

**New Construction & Renovation**

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Number of Buildings or Structures per Project</th>
<th>Total Insured Value (TIV)</th>
<th>Construction Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000</td>
<td>Projects with Single and Multiple Building(s) or Structure(s)</td>
<td>Up to $15M</td>
<td>Fire Resistive, Non Combustible</td>
</tr>
<tr>
<td>Deductible:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>Number of Buildings or Structures per Project</td>
<td>Total Insured Value (TIV)</td>
<td>Construction Class</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Projects with Multiple Building(s) or Structure(s) | Up to $10M (No single building or structure greater than $10mm in value) | • Masonry Concrete  
• Joisted Masonry  
• Hybrid Construction |
| Projects with No Vertical Construction (No Buildings or Structures) |                                           | • Grading - Site Prep Only  
• No Vertical Construction |
| Projects with Single and Multiple Building(s) or Structure(s) | $15M to $50M | • Fire Resistive  
• Non Combustible  
• Masonry Concrete  
• Joisted Masonry  
• Hybrid Construction  
• Wood Frame |
| Projects with Single Building or Structure | Up to $25M | • Fire Resistive  
• Non Combustible  
• Masonry Concrete  
• Joisted Masonry  
• Hybrid Construction  
• Wood Frame |
| Projects with Multiple Building(s) or Structure(s) | Up to $10M (No single building or structure greater than $10mm in value) | • Fire Resistive  
• Non Combustible  
• Masonry Concrete  
• Joisted Masonry  
• Hybrid Construction  
• Wood Frame |
| Projects with Single and Multiple Building(s) or Structure(s) | $50M & above | • Fire Resistive  
• Non Combustible  
• Masonry Concrete  
• Joisted Masonry  
• Hybrid Construction  
• Wood Frame |
| Single Building or Structure Projects | $25M & above | • Fire Resistive  
• Non Combustible  
• Masonry Concrete  
• Joisted Masonry  
• Hybrid Construction  
• Wood Frame |

*** Structural and Non Structural Renovation Projects with Single and Multiple Building(s) or Structure(s) – Deductibles are as per above categories, except in the event of water Damage, where the deductible is $25,000.

The deductible amount will be the responsibility of the contractor suffering the loss or damage and will not be reimbursed by the OCIP Insurance Program.

**Note:**
All Contractors’/Subcontractors’ shall be responsible for any loss or damage to their personal property. This would include, but is not limited to, tools, equipment, mobile construction equipment, or materials NOT intended to be a permanent part of the building, whether owned, borrowed, used, leased, or rented by any Contractor/Subcontractor. Any insurance purchased by the Contractors/Subcontractors, or self-insurance, shall be the Contractors’/Subcontractors’ sole source of recovery in the event of a loss.
3.4 Contractor’s Pollution Liability Insurance

Master policy names the Owner as the “Named Insured” and the Contractors/Subcontractors enrolled in the OCIP will be named “Additional Named Insured”. This Master policy is available for review by Contractors/Subcontractors, upon request to the Owner or the Program Administrator.

**Primary Coverage**

Bodily Injury or Property Damage from a pollution event as defined within the policy form resulting from covered operations or completed operations.

**Limits:**

- $5,000,000 Aggregate Per Policy Period
- $5,000,000 Per Occurrence
- Claims expense, including defense cost, within limit

**Deductible:**

- $10,000 Per Occurrence

The party legally responsible for any loss or damage shall, to the extent of such responsibility, pay the deductible.

3.5 OCIP Certificates and Policies

All Enrolled Contractors/Subcontractors will receive their own Workers’ Compensation policy. Certificates of Insurance will be furnished for the General Liability, Excess Liability (if applicable), Contractor’s Pollution Liability, and Builder’s Risk coverages. These policies are available for review by the Contractor/Subcontractor, upon request to the Owner or the Program Administrator. Such policies or programs may be amended from time to time and the terms of such policies or programs are incorporated herein by reference. Contractors/Subcontractors hereby agree to be bound by the terms of coverage, as contained in such insurance policies and/or self-insurance programs.
4.0 Contractor Requirements

*Throughout the course of the Project, Contractors will be responsible for reporting and maintenance of certain records as outlined in this section.*

All Contractors/Subcontractors shall cooperate with, and require their Subcontractors to cooperate with, the Owner and the Program Administrator, in regards to the administration and operation of the OCIP. Each Contractor must include this document with their bid specifications to any and all Subcontractors.

**Responsibilities of the Contractor include:**

- Enrolling in the OCIP
- Including OCIP Provisions in all subcontracts, as appropriate
- Providing each Subcontractor with a copy of the OCIP manual
- Requiring that all eligible Subcontractors who will perform work at the job site are enrolled in the OCIP prior to working on the site
- Providing timely evidence of insurance to the SEWUP Department
- Notifying the SEWUP Department of all awarded subcontracts
- Maintaining and reporting monthly payroll records
- Complying with the OCIP Administrator's requests for information
- Complying with insurance, claim and safety procedures
- Paying deductible assessments promptly, as required
- Notifying OCIP Administrator immediately of any insurance cancellation or non renewal of Contractor required insurance
- Cooperating with the OCIP insurance policy requirements, including but not limited to, physical audit of payroll records by the insurance company or its representatives.

4.1 Contractor Bids & Change Orders - Removing Insurance Costs

The Owner / School District provides insurance for all eligible, Enrolled Contractors/Subcontractors for work performed at the project site(s). The Owner pay's the insurance premiums for the OCIP coverage’s described in this manual. Contractors/Subcontractors who are eligible for enrollment in the OCIP are required to exclude the cost of insurance that is provided by the OCIP, from its bid price for the proposed scope of work at the project site(s).

In addition, change orders should be priced by the Contractor / Subcontractor to exclude any costs of insurance for coverage’s that are provided by the OCIP. It is the responsibility of the contractor to ensure that their subcontractors of all tiers also exclude the cost of insurance.

4.2 Enrollment Compliance

Participation in the OCIP is mandatory but not automatic. Each Eligible Contractor/Subcontractor must comply with the following:
An Eligible contractor is not enrolled until the Program Administrator receives and approves the following items:

1) Completed Contract Enrollment Form, for each awarded contract, within ten (10) days of Contract Award and prior to commencement of On-site activities

2) Certificates of Insurance, evidencing Insurance for Workers’ Compensation & General Liability coverages for Off-Site locations, labor, and operations

3) Certificate of Insurance, including an Additional Insured Endorsement, naming the Owner as an Additional Named Insured, for Automobile Liability for both Project Site and Off-Site operations

4) Policy Declarations pages, including proof of rates from your current policies.

Note:
If there is a discrepancy on the Contract Enrollment Form, evidence of rates (policy rate & declaration sheets), may be requested by the Program Administrator.

OCIP Enrollment Form must be submitted by the following deadlines:

Prime Contractors: Within ten (10) days of Contract Award and prior to commencement of On-site activities

Subcontractors (All Tiers): Within ten (10) days of Contract Award and prior to commencement of On-site activities

All questions regarding enrollment compliance should be directed to the assigned OCIP Administrator.

Any Contractor/Subcontractor who enrolls in the OCIP after their start date will have to provide a No-Known-Loss Letter to the Program Administrator, along with enrollment documentation.

For any work under this contract, and until completion and final acceptance of the work by the Owner, the Contractors/Subcontractors shall, at their own expense, promptly furnish Certificates of Insurance to the Program Administrator before commencing work on the Project Site. Automobile Liability Insurance must be maintained for both Project Site and off-site operations.

4.3 Confirmation of Enrollment & Evidence of OCIP Coverages

Upon receipt of complete enrollment documents, the OCIP Administrator will acknowledge acceptance of the Eligible Contractor/Subcontractor into the Owner's OCIP, by issuing the following to each Enrolled Party:

1) Confirmation Letter, which will include your assigned Site Location Code required for claims reporting

2) OCIP Certificates of Insurance

3) Claims Kit

4) OCIP Forms
5) Project Site Monthly Payroll Report

6) Contractor’s Completion Notice

These documents, as issued by the OCIP Administrator, will clearly identify the effective dates of the OCIP coverages for the Contract. A separate Workers’ Compensation policy will be issued and sent to each Enrolled Party.

**Should an Enrolled Party perform work on several contracts/projects, an Enrollment Form must be completed for each contract.** The OCIP Administrator will issue confirmation letters and certificates of insurance to each Enrolled Party for each separate contract. However, only one individual Workers' Compensation policy (that will apply to all contracts/projects) will be issued to each Enrolled Party.

**Note:**
Verify that the Workers’ Compensation effective date, listed on your OCIP Certificate of Insurance, reflect the same date as your start date.

### 4.4 Contractor-Provided Insurance Coverage

For any work under this contract, and until completion and final acceptance of the work by the Owner, the Contractors/Subcontractors shall, at their own expense, promptly furnish Certificates of Insurance and an Additional Insured Endorsement to the Owner. Copies should be sent to the Program Administrator for both Project Site and Off-Site operations, before commencing work on the Project Site.

All required insurance shall be maintained, without interruption, from the date of commencement of on-site activities, until the date of the final payment or expiration of any extended period. Certificates and additional insured endorsements shall provide not less than thirty (30) days prior written notice to the Program Administrator, of any material change in the insurance, cancellation or non-renewal.

**Coverages Requiring an Additional Insured Endorsement**

**Additional Insured Endorsements**, the Owner must be specifically named on the Schedule of an Additional Insured Endorsement, under the section titled, “Name of Person or Organization”, as specified below:

1. **All Contractors/Subcontractors** must provide an additional insured endorsement for automobile liability.

2. **Ineligible Contractors/Subcontractors** (not enrolled), must provide an additional insured endorsement on both the **Automobile Liability** and **General Liability** policies, and a waiver of subrogation on workers’ compensation.

**Name of Person or Organization:**
c/o Statewide Educational Wrap Up Program (SEWUP)
2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501
Coverages Requiring Certificates of Insurance

Certificates of Insurance will be required, as evidence of the following coverages and limits.

1) **Automobile Liability Insurance.** Must cover all vehicles owned by, hired by, or used on behalf of the Contractors/Subcontractors for both Project Site and off-site operations with the following minimum limits of liability:

<table>
<thead>
<tr>
<th>Enrolled Contractors/Subcontractors</th>
<th>General/Prime Contractor</th>
<th>Subcontractor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Ineligible Contractors/Subcontractors - Not Enrolled</td>
<td>$2,000,000</td>
<td>$1,000,000</td>
</tr>
</tbody>
</table>

2) **Workers’ Compensation and Employer's Liability Insurance – Statutory Benefits (All States)**
   a. $1,000,000 Bodily Injury each Accident
   b. $1,000,000 Bodily Injury by Disease – Policy Limit
   c. $1,000,000 Bodily Injury by Disease – Each Employee

   Ineligible Contractors/Subcontractors (not enrolled) – must also provide a waiver of subrogation, in favor of the owner.

3) **General Liability Insurance,** to be provided as evidence of coverage for work performed off-site, minimum limits of liability are as follows:

<table>
<thead>
<tr>
<th>Enrolled Contractors/Subcontractors</th>
<th>General/Prime Contractor</th>
<th>Subcontractor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td></td>
<td>$2,000,000</td>
<td>$1,000,000</td>
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<td>$1,000,000</td>
</tr>
<tr>
<td></td>
<td>$2,000,000</td>
<td>$1,000,000</td>
</tr>
</tbody>
</table>

Bodily Injury and Property Damage
Per Occurrence
General Aggregate
Products/Completed Operations Aggregate
Personal/Advertising Injury Aggregate
### Ineligible Contractors/Subcontractors - Not Enrolled

<table>
<thead>
<tr>
<th>General/Prime Contractor</th>
<th>Subcontractor</th>
<th>Bodily Injury and Property Damage Per Occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,000,000</td>
<td>$1,000,000</td>
<td></td>
</tr>
<tr>
<td>$2,000,000</td>
<td>$1,000,000</td>
<td>General Aggregate</td>
</tr>
<tr>
<td>$2,000,000</td>
<td>$1,000,000</td>
<td>Products/Completed Operations Aggregate</td>
</tr>
<tr>
<td>$2,000,000</td>
<td>$1,000,000</td>
<td>Personal/Advertising Injury Aggregate</td>
</tr>
</tbody>
</table>

4) Any other insurance coverage as required by contract

These coverages must be maintained for Off-Site labor, locations, and operations. Certificates of Insurance for these coverages must be filed with the Owner and Program Administrator within ten (10) days of Notice of Award, by all Contractors/Subcontractors and prior to commencement of on-site activities. All required insurance shall be maintained, without interruption, from the Notice to Proceed date, until the date of the final payment or expiration of any extended period. The Owner must be named as the Certificate Holder, c/o Statewide Educational Wrap Up Program, as specified below:

Certificate Holder:
(Insert School District Name)
c/o Statewide Educational Wrap Up Program
2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501

Furthermore, the policies shall provide not less than thirty (30) days prior written notice to the Program Administrator, of any material change in the insurance, cancellation, or non-renewal.

#### 4.5 Contractor’s Compliance with Other Forms and Procedures

All Eligible Contractors/Subcontractors are required to complete and submit the following forms:

**Project Site Monthly Payroll Report**

Project Site Monthly Payroll Reports must be submitted to the Program Administrator on a monthly basis, until the completion of the contract. This report must summarize the unburdened payroll by Workers’ Compensation Class Code. Certified payroll is not a requirement of the OCIP and cannot be accepted. If the Project Site Monthly Payroll Report is not submitted to Program Administrator on a monthly basis, the Construction Manager and/or Owner can withhold payment until the report is received. Contractor agrees to keep and maintain accurate and classified records of their payroll for operations at the Project Site. This payroll information is submitted to the OCIP Insurance Carrier. At the end of each contract, a carrier audit may be performed using the reported payroll.

Should no work be performed on the Project Site during a given month, each Enrolled Party is required to submit a form stating that “Non-Performance.” For those Enrolled Parties performing Work under multiple contracts, for each contract, a Monthly Payroll Report is required each month until contract is finalized.
Workers’ Compensation Insurance Rating Bureau Requirements

1) Payroll Reporting for Each Workers’ Compensation Policy Issued

Once an Eligible Contractor/Subcontractor is enrolled into the OCIP, the Program Administrator will issue a separate Workers’ Compensation Policy. All Enrolled Contractors/Subcontractors will need to comply with the rules and regulations of the California Workers Compensation Insurance Rating Bureau (WCIRB). This requires each Enrolled Party to maintain payroll records for each Contract under the policy issued. Such records will allocate the payroll by Workers’ Compensation classification(s) and exclude the excess or premium paid for overtime (i.e., only the straight-time rate will apply to overtime hours worked).

2) Insurance Company Payroll Audit

Each Enrolled Party must properly classify payrolls, as these are reported to the rating bureau for calculation of future Experience Modifiers for the Enrolled Party’s firm. All Enrolled Parties shall make available for inspection and copying their respective company books, vouchers, contracts, documents, and records, of any and all types, for physical inspection by the auditors of the OCIP insurance carrier(s) or Owner’s representatives. Availability of records must be for a reasonable time during the policy period, any extension, or during a final audit period, as required by the OCIP Insurance Policies.

Contractor’s Completion Notice

Contractor’s Completion Notice must be submitted to the Program Administrator upon completion of work at the Project Site, which includes punch list items, but not warranty or service contract work. This form evidences all enrolled Contractors’/Subcontractors’ actual start and completion dates, per each contract. This information is used to confirm that each Workers’ Compensation Policy was issued with correct policy term dates, covering the Contractors/Subcontractors for the duration of their Work at the Project Site. This information is subsequently submitted to the WCIRB.
5.0 Occupational Safety and Health Compliance

All Contractors/Subcontractors are expected to comply with all applicable local, state, and federal occupational safety and health. If additional safety and health requirements are set forth in the contract specifications, all contractors shall comply with these requirements.

It is the responsibility of each Contractor/Subcontractor to maintain an environment free of recognized hazards. All Contractors/Subcontractors shall exercise reasonable care to prevent work-related injuries; property and equipment damage at the Project, as well as minimize risk to the public and third party property.

In the event of an accident, it shall be the responsibility of the employing and/or responsible Contractor/Subcontractor to see that injured workers or members of the public are provided immediate medical treatment. All appropriate medical and claim forms must be filed in accordance with the claim procedures developed for this Project by Keenan & Associates, hereinafter called “Program Administrator.” This includes notification to the appropriate state authorities, if necessary.

The Program Administrator shall conduct periodic loss control surveys on behalf of the District. These surveys will focus on evaluating the Contractors’/Subcontractors’ efforts to minimize loss, assist in identifying loss exposures, and to recommend appropriate corrective measures. The Program Administrator is a resource to supplement the safety and loss prevention activity of Contractors/Subcontractors. Its loss control survey activities or other activities of the Program Administrator and/or OCIP insurers do not in any way relieve the Contractors/Subcontractors of their responsibilities for Project safety.

In addition local, state, and federal occupational safety and health laws, the following standards apply to all OCIP Enrolled and Non-Enrolled Contractors/Subcontractors.

5.1 Safety Orientation

a. Contractor/Subcontractor employees shall be provided with a project specific safety orientation prior the start of the project. At a minimum, the orientation will address the following items:
   i. The District’s site safety requirements.
   ii. Site specific safety hazards and protective measures for these hazards.
   iii. Emergency telephone numbers and procedures.
   iv. Local medical clinic/hospital information within the Medical Provider Network (MPN).

5.2 Program Management

a. Each Contractor/Subcontractors shall have the following safety programs:
   i. Injury and Illness Prevention Plans
   ii. Hazard Communication Programs
   iii. Heat Illness Prevention Plans

b. Each Contractor/Subcontractor shall have an onsite competent person responsible for occupational safety and health.
5.3 Site Safety

According to industry practices, it is the responsibility of contractors of all tiers to exercise reasonable care to prevent work-related injuries; property and equipment damage at the project site, as well as minimize risk to the third-party persons and property. Contractors/Subcontractors of all tiers shall be expected to comply with the following safety and loss control requirements:

a. All Subcontractors shall identify their contact person(s) to the General or Prime Contractor.

b. All Contractors/Subcontractors shall follow District procedures for dealing with the media.

c. All construction employees shall wear clothing suitable for the weather and work conditions. At a minimum, this shall be short sleeved shirts, long pants, and leather or other protective work shoes or boots.

d. Alcohol is prohibited on District property at all times.

e. Contractors/Subcontractors will be required to respond to all District complaints about objectionable levels of dust or noise and will be required to provide prompt and appropriate abatement.

f. Construction personnel cannot enter District grounds other than the construction site unless accompanied by District personnel, and are allowed only “incidental” contact with students. Violations of these requirements by any construction employee will result in a mandatory background check of that employee – including fingerprinting – as required by state law.

g. All prime contractors must attend the site specific pre-construction meeting.

h. No sexual reference or preference shall be permitted on any piece of clothing or the hardhat. Any employee observed disregarding this policy shall be removed from the job site until further notice.

i. All Contractors/Subcontractors shall control the break time activities of the employees to assure the cleanup of all soda cans, food wrappers, plastic bottles, or food containers from the break area. Such areas shall be cleaned immediately after the break and all waste placed in trash receptacles. No glass containers are permitted on the site.

j. Theft or willful damage to any property of the District, student, or other contractors will be prosecuted fully.

k. All Contractors/Subcontractors will advise non-English speaking employees in their native language either in a written format or via an interpreter of these policies.

5.4 Mandatory 6' Fall Protection

a. Contractor/Subcontractor employees shall be protected from fall exposures of 6 feet or greater. Activities include but are not limited to:

   i. Steel erection
   ii. Decking
   iii. Roofing
   iv. Framing
   v. Scaffold work
   vi. Work performed from ladders
b. A safety monitor as means of fall protection is prohibited.

c. Ladder jacks, lean-to, and prop-scaffolds are prohibited.

d. Contractor/Subcontractors are required to provide training to their employees who might be exposed to a fall hazard prior to the exposure or upon hiring. This training shall be documented and available for review.

e. Methods of fall protection include but are not limited to the following:

   i. Railings
   ii. Covers for Floor, Roof, and Wall Openings
   iii. Personal Fall Arrest Systems, Personal Fall Restraint Systems, and Positioning Devices
   iv. Controlled Access Zones

f. The design and construction of railings shall conform to the Cal/OSHA Construction Safety Orders.

g. The minimum parapet height allowed for fall protection is 42 inches or greater.

h. Covers used to cover floor, roof, and wall openings shall be secured in place to prevent accidental removal or displacement and shall be marked in accordance with Cal/OSHA Construction Safety Orders.

i. Covers used to cover floor and roof openings shall be capable of safely supporting the greater of 400 pounds or twice the weight of the employees, equipment and materials that may be imposed on any one square foot area of the cover at anytime.

j. Controlled access zones shall be defined by a control line or other means that restricts access. Each line shall have a minimum breaking strength of 200 pounds. Signs shall be posted to warn unauthorized employees to stay out of the controlled access zone.

k. Control lines shall consist of ropes, wires, tapes, or equivalent materials. Control lines shall be erected and supported in accordance with Cal/OSHA Construction Safety Orders.

5.5 Crane Safety

a. In accordance with Title 8, California Code of Regulations, section 5006.1, employers shall only permit operators who have a valid certificate (license) of competency to operate cranes. The operator shall have his license on his person, readily available for review.

b. All cranes used in lifting service, exceeding 3 tons rated capacity, and their accessory gear shall not be used until the employer has ascertained that such equipment has been certificated in accordance with Cal/OSHA as evidenced by current and valid documents. Certificates (annual and quadrennial) attesting to current compliance with testing and examination standards shall be maintained, readily available for each crane.

b. The contractor shall provide an erection plan and procedure for erection of trusses and beams over 25 feet long. The erection plan and procedure shall be prepared by a civil engineer currently registered in California. This plan and procedure shall be followed and kept available on the job site.
5.6 Return To Work

The District and OCIP Carrier are committed to working with all Enrolled Contractors and Subcontractors to promote the successful & timely return to work of injured employees following a work related injury. The purpose of this policy is to ensure that Enrolled Contractor/Subcontractor employees who temporarily cannot return to their normal duties due to job-related injury or illness, but can safely perform transitional duties while recovering is offered appropriate transitional duties for a limited time only.

a. Each Enrolled Contractor/Subcontractor will cooperate with the OCIP Carrier to facilitate the return to work of any injured employee capable of safely performing transitional duties.

b. When the employee is released to transitional duties, it is the Enrolled Contractor/Subcontractor’s responsibility to facilitate the injured employee's return to work.

c. The Enrolled Contractor/Subcontractor is expected to accommodate the injured employee to the fullest extent and facilitate the return to work.

d. It will be the responsibility of the Insurance Carrier’s Adjuster to maintain communication with the treating physician and the Enrolled Contractor/Subcontractor to facilitate the prompt return of an employee to full work status.
6.0 Claims Reporting

Accident/Claims Reporting Procedures - Overview

This section describes the basic procedures for reporting SEWUP claims: Workers’ Compensation, General Liability, Pollution Liability, and Damage to the Project (Builders Risk).

The OCIP Administrator provides Claims Kits to all Enrolled Contractors and Enrolled Subcontractors at time of enrollment. These kits include required claim forms and postings. Additional kits or claims forms can be obtained from the OCIP Administrator upon request.

6.1 Workers’ Compensation Claim Reporting & Procedures

If the injury requires a doctor (or medical office) visit or involves lost time, please follow the procedures listed below.

Contractors'/Subcontractors’ on-site personnel must follow these procedures if any employee is involved in an accident or occurrence resulting in bodily injury or death:

The main responsibility for any Contractor and Subcontractor is first to see that the injured worker receives immediate medical care. Immediately contact 911 for any serious, traumatic, and life-threatening injuries.

If an employee reports a work injury or illness that is minor and does not require a doctor visit or time off from work, the supervisor should refer the employee to the nearest First Aid Treatment available at the jobsite.

Workers’ Compensation Accident Claims Reporting

Call Arch Insurance Group Construction Division at 1-877-265-5186 to report the injury. Access the Workers’ Compensation Claim Kit, sent to you by the Program Administrator, which contains forms to be completed by employee and employer, as well as accident reporting guidelines. Have the following items ready:

- SEWUP Workers’ Compensation Policy Number
- SEWUP Site Location Code, which is assigned by the Program Administrator
- Identify your company as being part of the SEWUP

Medical Provider Network (MPN)

Arch Insurance Group, the Statewide Educational Wrap Up Program’s insurance carrier, has implemented the following Medical Provider Network (MPN):

Gallagher Bassett Platinum MPN

The above MPN is to be utilized for the medical treatment of injured employees, unless the employee has pre-designated their medical provider prior to the date of loss. In emergency situations, it is always recommended that the injured worker be treated at an emergency medical facility first, and then sent to a physician in the Medical Provider Network (MPN).
MPN Regulations & Guidelines:

- California MPN rules and regulations require that the injured worker must receive the Full Written MPN Notification when an injury is reported, or at the time of injury. The English version is given to English speaking employees and the Spanish version is given to Spanish speaking employees. The Full Written MPN Notification must also be given to the injured worker when changing to and transferring open claims to the Gallagher Bassett Platinum MPN.

- The MPN regulations are silent about Employee Acknowledgement Letters. As an employer, you have the right to use acknowledgement letters for your employees to sign when you give your employee the Full Written MPN Notification.

- An MPN Panel Card shall be posted at SEWUP Project Jobsite, Displaying the Name, Address and a Map of Designated Medical Clinic close to the jobsite.

- **For locating participating medical providers** within the Gallagher Bassett Platinum MPN, use your Internet Browser to access the below website, which will provide links for locating a medical provider within the network by specialty and by location,

  www.talispoin.com/cvty/gbmpn

Workers’ Compensation Form Requirements

The Labor Code requires that an employee report any injury immediately to the employer. There are essential requirements for both the employer and employee to perform, once the injury has actually been reported.

The Labor Code provides for possible penalties to be assessed if the following time lines are not met:

- Provision of the Employee Claim Form, DWC-1; report within one (1) working day of the employer’s knowledge of a disability or injury beyond first aid. Each employer is responsible for providing this form to an injured employee. Should the employee not be available for hand delivery, mail the DWC-1 to the employee at their home address.

- Provision of the Employer’s Report of Injury, Form 5020; report, within five (5) days of knowledge, every occupational injury or illness which results in lost time beyond the date of the incident, or requires medical treatment at a medical facility. In addition, every serious illness/injury or death must be reported immediately by telephone or fax to the nearest office of the California Division of Occupational Safety and Health.

6.2 General Liability Claim Reporting

Contractors/Subcontractors must immediately report all third party accidents at the Project Site involving bodily injury, death, or any damage to property to the following:

- Arch Insurance Group Construction Division - Telephonic Reporting - **1-877-265-5186**
- Program Administrator (SEWUP) – Email: SEWUP@keenan.com, Phone: (800) 654-8102 or Fax: (310) 787-8838
Note:
Always take appropriate emergency measures to prevent additional injury or damage, including contacting police and fire authorities as required by law.

6.3 Builder's Risk Claim Reporting
Contractors/Subcontractors must immediately report all property damage to your work or work of any other Contractor/Subcontractor at the Project Site, to the following:

- Ace USA Property Claims – Email: Propertyfirstnotices@acegroup.com, Phone: (800) 433-0385, or Fax: (302) 467-7855
- Program Administrator (SEWUP) – Email: SEWUP@keenan.com, Phone: (800) 654-8102 or Fax: (310) 787-8838

6.4 Contractor's Pollution Liability Claim Reporting
Contractors/Subcontractors must immediately report all third party accidents related to a known or suspected pollution incident at the Project Site involving bodily injury, death, or any damage to property to the following:

- Arch Insurance Group Construction Division - Telephonic Reporting - 1-877-265-5186
  Program Administrator (SEWUP) – Email: SEWUP@keenan.com, Phone: (800) 654-8102 or Fax: (310) 787-8838

6.5 Automobile Claim Reporting
NO coverage is provided for automobile accidents under the OCIP. It is the sole responsibility of each Contractor and Subcontractor to report claims involving their automobiles to their own insurance carrier.

6.6 Instructions and Procedures – Litigation Papers, Legal Documents, etc.
If your firm is served with a lawsuit arising out of your involvement with the Owner's Project, or if receipt of litigation papers or legal documents is your first notice of a claim, forward to the following:

- Arch Insurance Group Construction Division - Telephonic Reporting - 1-877-265-5186
- Program Administrator (SEWUP) – Email: SEWUP@keenan.com, Phone: (800) 654-8102 or Fax: (310) 787-8838

6.7 Investigation Assistance/Confirmation of Claim Receipt
All Contractors/Subcontractors will assist in the investigation of any accident or occurrence involving injury to persons or property. All Contractors/Subcontractors must cooperate with the companies
involved in adjusting any claim by securing and giving evidence and obtaining the participation and attendance of witnesses required for the investigation and defense of any claim or suit.

Upon receipt of the claim or incident from the Contractor, the respective OCIP insurance carrier will send a claims acknowledgment letter with the assigned claims file number.

Always cooperate with the Owner or the OCIP insurer representatives in the accident investigation.
7.0 Required Project Forms

7.1 Contract Enrollment Form

7.2 Frequently Asked Questions (FAQ’s) for Contractor Enrollment Form

7.3 Project Site Monthly Payroll Report

7.4 Contractor's Notice of Completion

7.5 First Report of Injury (5020)

7.6 Workers’ Compensation Claim Form (DWC-1)

7.7 ACORD Property Loss Notice
7.1 OCIP Contract Enrollment  (Click inside of form below to open document)

OCIP Contract Enrollment Form

Form must be completed by all Contractors/Subcontractors of all tiers on all initial/new contracts and any additional contracts and/or change orders for each project. If using subcontractors, you may use OCIP Tools Online to report each subcontract or complete the "Expected Subcontractor" section on the next page. Parent Contractor is responsible for 100% subcontractor compliance with OCIP requirements as set forth in their contract and the SEWUP Project Insurance Manual.

District: ___________________________  Project: ___________________________

CONTRACTOR DETAILS

Contractor Legal Name: ___________________________  DBA or Subsidiary: __________

[ ] Corporation  [ ] Sole Proprietor  [ ] Partnership  [ ] Joint Venture  [ ] LLC

PEIN#: ___________________________  Contractor License #: ___________________________

Business Address (Address as listed on Insured Certificate): ___________________________

Office Address (If Different from Business Address): ___________________________

Main Enrollment Contact  Phone: ___________________________  Fax: ___________________________

Insurance Contact: ___________________________  Email: ___________________________

Paysroll Contact: ___________________________  ___________________________

Site Contact/Project Mgr: ___________________________

CONTRACT DETAILS

[ ] General/Prime Contractor  [ ] Subcontractor  [ ] Tier Subcontractor  [ ] Temp./Labor, Time & Material, or Other: ___________________________

Awarding Contractor: ___________________________  Prime Contractor: ___________________________

Contract Value: ___________________________  Self Performed Work: % ___________________________

[ ] Estimated Payroll: ___________________________

Est. # of Subcontractors: ___________________________  Subcontracted Work: % ___________________________

Estimated Payroll: ___________________________

If using subcontractors, please be sure to complete subcontractor information on next page.

Contract Award Date: ___________________________  Est. Start Date: ___________________________

Est. Completion Date: ___________________________

Description of Work: ___________________________

Off-Site Work Performed?  [ ] YES  [ ] NO  If Yes, Description of Off-site work: ___________________________

CONTRACTORS CURRENT INSURANCE INFORMATION

Insurance Broker or Agency: ___________________________  Agent/Broker Contact: ___________________________

Phone: ___________________________  Fax: ___________________________  Email: ___________________________

WORKERS COMPENSATION INSURANCE

Name of Insurer: ___________________________  WC Policy #: ___________________________

Bureau #: ___________________________  Effective From: ___________________________

To: ___________________________  Deductible / SIR: ___________________________

Anniversary Rating Date: ___________________________

WORKERS COMPENSATION DETAILS  (Estimated Project Site Payroll Only)

<table>
<thead>
<tr>
<th>WC Class Code</th>
<th>WC Class Code Description</th>
<th>Rate</th>
<th>Est. Man Hours</th>
<th>Est. Payroll</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
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</tbody>
</table>

Was Experience Modifier included in your above WC Class code(s)?  [ ] YES  [ ] NO

Subtotals: ___________________________  Experience Modifier: ___________________________

Modified Premium: ___________________________  $____________________

Plus/Minus Rate Deviations or Premium credits: ___________________________  $____________________

(Cost A) Total Workers’ Compensation Cost: ___________________________  $____________________

Attach Copies of Work Comp rate pages with enrollment form.
# OCIP Contract Enrollment Form

## GENERAL & EXCESS LIABILITY INSURANCE

<table>
<thead>
<tr>
<th>Classification Description</th>
<th>Based on Payroll, Receipts or Other</th>
<th>Rate</th>
<th>Per $100 / $1000 or Other</th>
<th>Total Value (Payroll, receipts, or Other)</th>
<th>Liability Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Liability 1</td>
<td>$</td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>General Liability 2</td>
<td>$</td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Excess/Umbrella Liability</td>
<td>$</td>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Attach copies of GL and XL declarations and rate pages with enrollment form.

## TOTAL INSURANCE COST

```
(Cost A) Margin Factor (Apply your Mark-Up Against Current Cost): $ __________
(Cost A + B + C) Total Insurance Cost: $ __________
```

## EXPECTED SUBCONTRACTORS

<table>
<thead>
<tr>
<th>Company Name:</th>
<th>Contractor License #:</th>
<th>Est. Contract Value:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of Work:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact:</td>
<td>Phone:</td>
<td>Fax:</td>
</tr>
</tbody>
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<td>Contact:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Contact:</td>
<td>Phone:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

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**DECLARATIONS UNDER PENALTY OF PERJURY, UNDER THE LAWS OF THE STATE OF CALIFORNIA, THAT:**

1. The information contained in this document is true and correct.
2. I hereby understand that enrollment is contingent upon receipt and acceptance of this form and any applicable certificates of insurance. Should I submit an incomplete form, Kenney's SEWUP department will contact me and my firm will not be enrolled until I provide all necessary information in its entirety.
3. I have read and understand the information contained in the bid specifications regarding the insurance coverages provided through the OCIP. My firm understands and accepts the insurance provided under the OCIP.
4. My firm agrees to comply with the requirements of the OCIP and follow the administrative procedures as outlined in the bid specifications.

Signature: ____________________________  Date: ____________________________

Kenney & Associates, 2355 Crenshaw Blvd., Ste. #200, Torrance, CA 90501, Ann: SEWUP, Phone (310) 212-6363, Fax (310) 767-8538, Email SEWUP@keeney.com License # 0451271
7.2 Frequently Asked Questions (FAQs) (Click inside of form below to open document)

Frequently Asked Questions (FAQs): Contract Enrollment Form (Click inside of form below to open document)

Contract Enrollment Form

Q: My firm has not been awarded a contract, how can I complete the ‘Contract Details’ Section on page 1?
A: All information in this section should be completed as an estimate, i.e. who you plan to have a contract with, estimated start date, estimated contract amount for self-performed work, etc. You may write ‘TBD’ for Contract Award Date. Please use estimates for all other categories.

Q: Why do I have to provide my Broker/Agent information?
A: We ask for this information, so that if you request us to do so, we can contact your Broker/Agent for information that you are unsure of, i.e., General Liability rate, etc.

Q: Why do I have to provide my estimated insurance cost for this project if the district is providing insurance coverages?
A: This information is provided to the district so that a comparison can be made between contractor insurance costs and OCIP insurance costs.

Q: How do I complete the ‘Workers’ Compensation’ Section on page 2?
A: Please review the sample on the last page of this document.

Q: Where do I find the Workers’ Compensation Class Code(s) and Rate information?
A: You can find this information on your Workers’ Compensation Policy Declarations Pages (first few pages of your policy), on the State Fund monthly payroll report form, if applicable, or by contacting your Broker/Agent.

Q: How do I calculate the on-site straight time payroll?
A: The on-site straight time payroll is the base pay for each particular labor classification. In the attached Sample, the company estimates that it will take their apprentice plumbers 150 hours to complete the job. If these apprentice plumbers make $25.00/hr, you would multiply this by 150 hours, which totals $3,750.00 in payroll (150 x $25.00 = $3750).

Q: How do I calculate the WC Premium?
A: You will multiply the on-site straight time payroll by the WC rate and divide by 100. In the example below, (3750 X 15.15)/100 = $568.125 (rounded up = $568.13)

Q: How do I calculate the modified premium?
A: Multiply the Workers’ Compensation Experience Modifier by the total WC premium. In the example below, .80 x $1030.13 = $824.10

Q: What do I put in the plus/minus rate deviations or premium credits column?
A: This information can be found on your Workers’ Compensation Declarations Pages or by contacting your Broker/Agent. This does not apply to every contractor and can be left blank.
Q: Where do I find the General Liability rate?
A: You will find this on your General Liability Policy Declarations Pages (first few pages of your policy) or by contacting your Broker/Agent. Please note that you may have multiple rates, i.e., a premises-operations rate and a completed-operations rate or you may have GL rates based on your labor classifications, such as one for apprentices and one for journeymen. If you have multiple rates, please add these rates together. Example: premises-ops rate = $6.25 per $100 of payroll and completed-ops rate = $4.50 per $100 of payroll, the total GL rate to be listed on the Contractor Profile is $10.75 per $100 of payroll.

Q: How do I calculate the General Liability premium?
A: Per the example below, if the GL rate is $5.25 per $100 of payroll, the premium would be $472.50. ($9000 (estimated payroll in WC section)/100) x $5.25 = $472.50. An example based on contract value is: contract amount is $25,000: (25,000/100) x 5.25 = $1312.50

Q: I don’t have an Excess Liability or Umbrella Policy, how can I complete that section?
A: Please write ‘N/A’ in this section.

Q: What do I put for Margin Factor?
A: Margin Factor is your profit or mark-up amount. This may not apply to all contractors, please write ‘N/A’ in this section.

Q: I expect to use multiple subcontractors; can I attach a subcontractor list instead of completing the section on page 3?
A: Yes. You may substitute a typed or handwritten list instead of completing this section.

Q: I just renewed my policies and don’t have rate pages and/or certificate of insurance, will this keep me from getting enrolled?
A: No; however, we ask that you contact your Broker/Agent to provide you with proof of coverage and rates on company letterhead. Once your certificate of insurance and policy are received, please forward your rate pages and certificate to the Program Administrator.
Each Contractor and Subcontractor of every tier is required to submit a list of job/WC classifications and their respective estimated payrolls and man-hours for all employees that will be working at the project site. This information must be submitted for each.

### Workers' Compensation Section

<table>
<thead>
<tr>
<th>Description of Work</th>
<th>WC Class Code</th>
<th>On-Site Man-hours</th>
<th>On-Site Straight</th>
<th>WC Rate $100/Payroll</th>
<th>WC Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plumber &lt;$22/hr.</td>
<td>5183</td>
<td>150</td>
<td>3750</td>
<td>15.15</td>
<td>$568.13</td>
</tr>
<tr>
<td>Plumber &gt;$22/hr.</td>
<td>5187</td>
<td>150</td>
<td>5250</td>
<td>8.80</td>
<td>$462.00</td>
</tr>
</tbody>
</table>

|                      |               |                   |                  |                      |            |
| Totals              | 300           | $9,000            |                  |                      | $1030.13   |

Modified Premium is: Total Premium X Experience Modifier
Experience Modifier: .80
Modified Premium: $824.10

Plus/Minus Rate Deviations or Premium Credits
Credit/Deduction: $N/A

**Total Workers' Compensation Insurance Cost** $824.10

Workers' Compensation Insurance Carrier Name: ABC INSURANCE CO
Policy No: ABC-12345
Policy Term: 01-01-07 TO 01-01-08
Workers' Comp Bureau ID No: 123456
Anniversary Rating Date: 01-01-08

### General Liability Section

<table>
<thead>
<tr>
<th>General Liability Insurance Carrier Name:</th>
<th>DEF INSURANCE CO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy No: DEF-5566</td>
<td>Policy Term: 01-01-07 TO 01-01-08</td>
</tr>
<tr>
<td>Aggregate Limit: $2,000,000</td>
<td>GL Policy Deductible: $100,000</td>
</tr>
<tr>
<td>GL Rate: $5.25 Per $1000 OR $5.50 Per $100</td>
<td>Products &amp; Comp/Ops Limit: $1,000,000</td>
</tr>
<tr>
<td></td>
<td>Based On: □ Receipts OR □ Payroll</td>
</tr>
</tbody>
</table>

**Total General Liability Insurance Cost** $472.50

### Umbrella/Excess Liability Section

Provide your current Umbrella/Excess Liability Carrier Name: N/A
Policy No: N/A
Policy Term: TO
Policy Rate: $ Based On: □ Receipts OR □ Payroll OR □ Other

**Total Umbrella / Excess Liability Insurance Cost** $N/A

**Margin Factor (Apply your Mark-Up Against Current Cost)** $N/A

**TOTAL INSURANCE COST** $1296.60
**PROJECT SITE MONTHLY PAYROLL REPORT**
Due on the 10th of each month (for previous month labor)

<table>
<thead>
<tr>
<th>Workers' Compensation Class Code</th>
<th>Description</th>
<th>On-site man hours</th>
<th>Payroll*</th>
</tr>
</thead>
<tbody>
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| TOTAL                           | 0.00        | $0.00             |

Is this your final payroll report?  [ ] YES  [ ] NO
If Yes, submit final report with Contract Completion Notice. If this is not your final report, payroll must be submitted each month until contract work is complete. If there is no on site labor, 0 hours must be reported and submitted.

I CERTIFY THAT THE INFORMATION REPORTED ABOVE IS TRUE AND ACCURATE. NOT REPORTING ACCURATE PAYROLL INFORMATION COULD AFFECT YOUR ExMod - EXPERIENCE MODIFICATION RATING WITH THE WORKERS' COMPENSATION INSURANCE RATING BUREAU (WCIRB).

Signature: ______________________  Title: ______________________  Date: ______________________

*Only report payroll for work performed on-site. Do not include overtime wage rates, use straight time wage rates only, i.e., employee earns $20/hr. and works 10 hours in one day, you would report $200.00 ($20.00 x 10). Payroll remuneration that is taxable to employee and paid by your company, is reported to WCIRB.
Contractor's Completion Notice

District Name: ________________________________

Project Name: ________________________________

IMPORTANT NOTIFICATION – PLEASE READ

Contractor and Subcontractor agrees to complete this form and return to Keenan & Associates upon completion or termination of work activities under this contract. Please include, with this form, any supporting documents for final contract value (if different from initial contract value).

Contractor/Subcontractor Legal Name: ________________________________

Contractor/Subcontractor obs Name: ________________________________

Address: _________________________________________________________

Site Location Code/Contract Number: ________________________________

Initial Contract Value: $ __________________ Final Contract Value: $ _____________

Start Date on Site: ___________________________ Last Day on Site: ___________________________

*This would include work performed on final closeout or punch-list items and should not include warranty work.

Parent Contractor (Company Name): ________________________________

Parent Contractor Contact Name (Print): ________________________________ Title: ________________________________

Signature (Parent Contractor): __________________________________________ Date: ________________________________

Contact Name (Print): ________________________________ Title: ________________________________

Signature (Contractor/Subcontractor): ____________________________________ Date: ________________________________

Keenan & Associates
SEWUP Department
2355 Crossbow Blvd., Ste. #220.
Phone (310) 312-0344; Fax (310) 787-8836
Sewup@keenan.com
www.sewup.org
License No. 0451271
7.5 First Report of Injury (5020) (Click inside of form below to open document)

District Name: ____________________  Project Name: ____________________

State of California

EMPLOYER’S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

PLEASE COMPLETE (TYPE, IF POSSIBLE). MAIL TWO COPIES TO: OSHA CASE NO.

<table>
<thead>
<tr>
<th>FATALITY</th>
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Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers’ compensation benefits or payments of guilty of a felony.

NOTICE: California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious illness/injury or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health

<table>
<thead>
<tr>
<th>1. FIRM NAME</th>
<th>1A. POLICY NUMBER</th>
<th>DO NOT USE THIS COLUMN</th>
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<thead>
<tr>
<th>2. MAILING ADDRESS (Number and Street, City, ZIP)</th>
<th>2A. PHONE NUMBER</th>
<th>Case No.</th>
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<thead>
<tr>
<th>3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)</th>
<th>3A. LOCATION CODE</th>
<th>Ownership</th>
</tr>
</thead>
<tbody>
<tr>
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| 4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc. | 5. STATE UNEMPLOYMENT INSURANCE ACCT NUMBER |
|--------------------------------------------------------------------------------------------|
|                                                                                           |                                         |

<table>
<thead>
<tr>
<th>6. TYPE OF EMPLOYER</th>
<th>PRIVATE</th>
<th>STATE</th>
<th>CITY</th>
<th>COUNTY</th>
<th>SCHOOL</th>
<th>DIST.</th>
<th>OTHER</th>
<th>GOV. – SPECIFY</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>7. EMPLOYEE NAME</th>
<th>8. SOCIAL SECURITY NUMBER</th>
<th>9. DATE OF BIRTH (mm dd yy)</th>
<th>Sex</th>
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<tbody>
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<thead>
<tr>
<th>10. HOME ADDRESS (Number and Street, City, ZIP)</th>
<th>10A PHONE NUMBER</th>
<th>Age</th>
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<tbody>
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<tr>
<th>11. SEX</th>
<th>MALE</th>
<th>FEMALE</th>
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<thead>
<tr>
<th>12. OCCUPATION (Regular job title – NO initials, abbreviations or numbers)</th>
<th>13 DATE OF HIRE (mm dd yy)</th>
<th>Daily Hours</th>
</tr>
</thead>
<tbody>
<tr>
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<thead>
<tr>
<th>14. EMPLOYEE USUALLY WORKS</th>
<th>14A. EMPLOYMENT STATUS (check applicable status at time of injury)</th>
<th>14B. Under what class code of your policy were wages assigned</th>
</tr>
</thead>
<tbody>
<tr>
<td>hours</td>
<td>total days per day _____ per week _____ wkly. hrs</td>
<td>Days/week</td>
</tr>
<tr>
<td></td>
<td>regular part time time part time temp seasonal</td>
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</tbody>
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<thead>
<tr>
<th>15. GROSS WAGES/SALARY</th>
<th>15 OTHER PAYMENTS NOT REPORTED AS WAGES/Salary (e.g., tips, meals, lodging, overtime, bonuses, etc.)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ PER</td>
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<thead>
<tr>
<th>16. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy)</th>
<th>17. DATE OF INJURY OR ONSET OF ILLNESS (mm dd yy)</th>
<th>18. TIME INJURY ILLNESS OCCURRED</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>A.M.</td>
<td>P.M.</td>
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<thead>
<tr>
<th>21. IF EMPLOYEES DIED, DATE OF DEATH (mm dd yy)</th>
<th>22. DATE LAST WORKED (mm dd yy)</th>
<th>23. DATE RETURNED TO WORK (mm dd yy)</th>
<th>24. IF STILL OFF WORK, CHECK THIS BOX</th>
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<td>A.M.</td>
<td>P.M.</td>
<td>A.M.</td>
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25. SALARY BEING CONT'D DURING INJURY/ILLNESS |

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<thead>
<tr>
<th>25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED</th>
<th>26. SALARY BEING CONT'D DURING INJURY/ILLNESS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Notice of Injury/Illness (mm dd yy)</td>
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<thead>
<tr>
<th>27. DATE OF EMPLOYER'S KNOWLEDGE OF INJURY/ILLNESS</th>
<th>28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy)</th>
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<tr>
<th>29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burns on right arm, tendinitis of left elbow, lead poisoning</th>
<th>30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number and Street, City)</th>
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<tbody>
<tr>
<td></td>
<td>30A COUNTY</td>
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<td>30B. ON EMPLOYER’S PREMISES</td>
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<td>YES</td>
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<tr>
<th>31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g. shipping department, machine shop.</th>
<th>32. OTHER WORKERS INJURED/ILL IN THIS EVENT?</th>
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<tbody>
<tr>
<td></td>
<td>Event</td>
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<td>Sec. Source</td>
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<tr>
<th>33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold</th>
<th>34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes into truck</th>
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<tbody>
<tr>
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<td>Extent of Injury</td>
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<tr>
<th>35. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS (e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld and burned right hand). USE SEPARATE SHEET IF NECESSARY</th>
<th>36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)</th>
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<tr>
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<td>36A. PHONE NUMBER</td>
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<tr>
<th>37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)</th>
<th>37A. PHONE NUMBER</th>
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<th>COMPLETED BY (type or print)</th>
<th>SIGNATURE</th>
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33
If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers’ compensation benefits. Attached is the form for filing a workers’ compensation claim with your employer. You should read all of the information below. Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the “Employee” section of the form, keep one copy and give the rest to your employer. Your employer will then complete the “Employer” section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can’t start until the claims administrator knows of the injury, so complete the form as soon as possible.

**Medical Care:** Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. For injuries occurring on or after 1/1/04, there is a limit on some medical services.

**The Primary Treating Physician (PTP):** is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a doctor of your choice. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers’ compensation, you may choose your own doctor immediately.

Within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

**Disclosure of Medical Records:** After you make a claim for workers’ compensation benefits, your medical records will not have the same privacy that you usually expect. If you don’t agree to voluntarily release medical records, a workers’ compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

**Payment for Temporary Disability (Lost Wages):** If you can’t work while you are recovering from a job injury or illness, you will receive temporary disability payments. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Si Ud. se lesiona o se enferma, ya sea física o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para trabajadores con su empleador. Ud. debe leer toda la información a continuación. Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete la sección del formulario designada para el “Empleado”, guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el “Empleado”, le dará a Ud. una copia fechada, guardará una copia, y enviará una al/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

**Atención Médica:** Su administrador(a) de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.

**El Médico Primario que le Atiende—Primary Treating Physician (PTP)** es el médico con toda la responsabilidad para dar el tratamiento para su lesión o enfermedad. Generalmente, su empleador selecciona al PTP que Ud. Verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico pre-designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o después de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento aplicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares ($10,000).

**Divulgación de Expedientes Médicos:** Después de que Ud. presente un reclamo para beneficios de compensación para los trabajadores, sus expedientes médicos no tendrán la misma privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un(a) juez de compensación para trabajadores posiblemente decidirá qué expedientes se revelarán. Si Ud. Solicita privacidad, es posible que el/la juez "seal" (mantenga privados) ciertos expedientes médicos.

**Pago por Incapacidad Temporal (Sueldos Perdidos):** Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres
**Return to Work:** To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

**Payment for Permanent Disability:** If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

**Vocational Rehabilitation (VR):** If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn’t offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

**Supplemental Job Displacement Benefit (SJDB):** If you do not return to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, your claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability. SJDB is a benefit for injuries occurring on or after 1/1/04.

**Death Benefits:** If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person’s workers’ compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers’ Compensation, or you can hear recorded information and a list of local offices by calling (800) 736-7401. You may also go to the DWC web site at www.dir.ca.gov. Link to Workers’ Compensation.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at www.californiaspecialist.org.
Employee: Complete the “Employee” section and give the form to your employer. Keep a copy and mark it “Employee’s Temporary Receipt” until you receive the signed and dated copy from your employer. You may call the Division of Workers’ Compensation and hear recorded information at (800) 736-7401. An explanation of workers’ compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers’ compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony.

Employee—complete this section and see note above.

1. Name. Nombre. ____________________________ Today’s Date. Fecha de Hoy. ____________________________
3. City. Ciudad. ____________________________ Date of Injury. Fecha de la lesión (accidente). ____________________________ Time of Injury. Hora en que ocurrió. _______ a.m. _______ p.m.
4. Address and description of where injury happened. Dirección/lugar dónde ocurrió el accidente. ____________________________
5. Describe injury and part of body affected. Describa la lesión y parte del cuerpo afectada. ____________________________
7. Signature of employee. Firma del empleado. ____________________________

Employer—complete this section and see note below.

9. Name of employer. Nombre del empleador. ____________________________
10. Address. Dirección. ____________________________
11. Date employer first knew of injury. Fecha en que el empleador supo por primera vez de la lesión o accidente. ____________________________
12. Date claim form was provided to employee. Fecha en que se le entregó al empleado la petición. ____________________________
13. Date employer received claim form. Fecha en que el empleado devolvió la petición al empleador. ____________________________
14. Name and address of insurance carrier or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora de seguros. ____________________________
15. Insurance Policy Number. El número de la póliza de Seguro. ____________________________
16. Signature of employer representative. Firma del representante del empleador. ____________________________
17. Title. Título. ____________________________
18. Telephone. Teléfono. ____________________________

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

☐ Employer copy
☐ Employee copy

☐ Claims Administrator
☐ Administrator de Reclamos

☐ Temporary Receipt/
☐ Recibo del Empleado

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor “felonia”.

Esta petición se le puede atender a través del servicio de atención telefónica al número: (800) 736-7401
### Accord Property Loss Notice Form

#### INSURED

<table>
<thead>
<tr>
<th>NAME AND ADDRESS OF INSURED</th>
<th>DATE OF BIRTH</th>
<th>NAME AND ADDRESS OF INSURED</th>
<th>DATE OF BIRTH</th>
</tr>
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<tr>
<th>RESIDENCE PHONE</th>
<th>BUSINESS PHONE</th>
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<tbody>
<tr>
<td>(A/C, No.)</td>
<td>(A/C, No., Ext.)</td>
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<thead>
<tr>
<th>NAME AND ADDRESS OF SPOUSE (IF APPLICABLE)</th>
<th>DATE OF BIRTH</th>
<th>RESIDENCE PHONE</th>
<th>BUSINESS PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(A/C, No.)</td>
<td>(A/C, No., Ext.)</td>
</tr>
</tbody>
</table>

#### LOSS

<table>
<thead>
<tr>
<th>KIND OF LOSS</th>
<th>POLICE OR FIRE DEPT. TO WHICH REPORTED</th>
<th>PROBABLE AMOUNT ENTIRE LOSS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DESCRIPTION OF LOSS &amp; DAMAGE (Use separate sheet, if necessary)</th>
</tr>
</thead>
</table>

#### POLICY INFORMATION

<table>
<thead>
<tr>
<th>MORTGAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO MORTGAGE</td>
</tr>
</tbody>
</table>

#### HOMESTORE POLICIES SECTION I ONLY

<table>
<thead>
<tr>
<th>A. DWELLING</th>
<th>B. OTHER STRUCTURES</th>
<th>C. PERSONAL PROPERTY</th>
<th>D. LOSS OF USE</th>
<th>DEDUCTIBLES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Describe additional coverages provided:

#### FIRE, ALLIED LINES & MULTI-PERIL POLICIES

<table>
<thead>
<tr>
<th>ITEM</th>
<th>SUBJECT OF INSURANCE</th>
<th>AMOUNT</th>
<th>% COINS</th>
<th>DEDUCTIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Describe additional coverages provided:

#### CUSTOMER SUPPORT

<table>
<thead>
<tr>
<th>CAT #</th>
<th>RICO #</th>
<th>ADJUSTERS ASSIGNED</th>
<th>ADJUSTER #</th>
<th>DATE ASSIGNED</th>
</tr>
</thead>
</table>

Reported by: Reported to: Signature of Insured: Signature of Producer:

ACORD 1 (2000/01) NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE © ACORD CORPORATION 1988
Applicable in Arizona
For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Applicable in Arkansas, District of Columbia, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, Pennsylvania and Virginia
Any person who knowingly and with intent to defraud any insurance company or another person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and [NY: substantial] civil penalties. In ME, D.C., LA, and VA, insurance benefits may also be denied.

Applicable in California
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in Florida and Idaho
Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony*.
* In Florida – Third Degree Felony

Applicable in Hawaii
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Applicable in Indiana
A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Minnesota
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada
Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire
Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in Ohio
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Oklahoma
WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
8.0 Frequency Asked Questions (FAQs)

An Owner Controlled Insurance Program (OCIP) Through The Statewide Educational Wrap Up Program (SEWUP)

1. Who is insured under an Owner Controlled Insurance Program?
The Owner and all enrolled Contractors and their enrolled Subcontractors of any tier who perform operations at the Project Site described in the Contract Documents are insured under the OCIP.

2. Who is managing the Owner Controlled Insurance Program?
Keenan & Associates is the Program Administrator for this Owner Controlled Insurance Program, otherwise known as Statewide Educational Wrap Up Program (SEWUP).

3. Is Project Site Defined?
Yes. Project Site is on file with the insurance company, as described in the applicable Contract Documents.

4. What insurance is provided to Contractors/Subcontractors under the Owner Controlled Insurance Program (OCIP)?
The Owner has agreed to procure the following insurance:

   a. Workers’ Compensation and Employer’s Liability
   b. General Liability Insurance for Personal Injury, Bodily Injury and Property Damage Liability
   c. Builder’s Risk
   d. Contractor’s Pollution Liability (course of construction only)

5. Does the OCIP cover any contractor’s equipment?
No. Contractors and Subcontractors must maintain this coverage.

6. Are there other types of insurance normally purchased by Contractors, which are not included?
Yes. Examples are:

   a. Bonds, if required by contract
   b. Contractor’s Automobile Liability and Physical Damage Insurance
   c. Contractor’s Equipment Floater
7. **Does the Contractor/Subcontractor insured under the OCIP have to provide evidence of insurance?**
   Yes. The contract requires that, prior to commencement of on-site activities; each Contractor/Subcontractor shall furnish a Certificate of Insurance evidencing coverage for:
   
   a. Workers’ Compensation
   b. General Liability

   Certificates of Insurance and Additional Named Insured Endorsements, specifically naming the Owner, are also required for:
   
   a. Automobile Liability

8. **How is the Contractor/Subcontractor’s bid to be submitted?**
   The Contractor/Subcontractor needs to submit their bid excluding certain insurance costs, as outlined in the Contract. Change Orders also need to be submitted without insurance costs.

9. **When will the Contractor/Subcontractor receive a Certificate of Insurance insuring them under the OCIP?**
   Eligible Contractors/Subcontractors awarded a contract will be furnished a Certificate of Insurance upon Program Administrator’s receipt and acceptance of the Contract Enrollment Form.

10. **Will all Contractors/Subcontractors receive information concerning their loss experience?**
    This information is available, upon request, from the Program Administrator.

11. **How long are the policies kept in-force for the Contractor/Subcontractor?**
    The policy periods commence on the date of “Award” and terminate as defined in the Contract Documents. The only extension is for General Liability “Completed Operations” which is for ten (10) years after Notice of Completion filed by the District.

12. **Does the OCIP provide coverage for truckers, vendors and suppliers?**
    No. Contractors/Subcontractors, whose sole duties are as truckers, vendors, or suppliers are not included in the program. If contracted with an on-site installer, vendors and/or suppliers should be enrolled in the OCIP for General Liability only, as it pertains to the contractual relationship of the installer’s on-site work.

13. **Are all Contractors/Subcontractors, of any tier, required to complete and submit their own OCIP forms, before they will be allowed to begin job site activity?**
    All Contractors/Subcontractors, regardless of tier, must complete a Contract Enrollment Form, prior to commencement of on-site activities. Upon acceptance by the Program Administrator, each Contractor/Subcontractor will receive an enrollment confirmation packet, which includes a Certificate of Insurance evidencing the OCIP coverages.
14. What document do I use to show my Agent/Broker and Insurer that I’m covered under the OCIP?
All contractors enrolled under the OCIP program receive individual workers’ compensation policies and Certificates of Insurance evidencing coverage under the OCIP program.

**Workers’ Compensation and Employers’ Liability Insurance Questions**

1. **What insurance company writes the Workers’ Compensation and Employer’s Liability coverage?**
   Arch Insurance Company.

2. **What is the coverage term?**
The coverage term for each Contractor/Subcontractor will coincide with the Start Date provided at OCIP enrollment. OCIP Workers’ Compensation policies are renewed each year until receipt of OCIP Contractor’s Completion Notice.

3. **How will the Contractor/Subcontractor’s payroll be classified?**
   Insurance Company will classify payrolls in accordance with California law under the Workers’ Compensation Insurance Rating Bureau regulations, classifications, rates and rating plans. The Monthly Project Site Payroll Form will be used for Contractors/Subcontractors’ monthly payroll submissions.

4. **Will Program Administrator inspect the job and make recommendations regarding loss control and safety?**
   Yes. The Program Administrator will conduct periodic loss control surveys on behalf of the Owner. These surveys will focus on evaluating the contractors’ efforts to control Workers’ Compensation, General Liability, and Builders Risk exposures. These surveys are intended to assist contractors in identifying these exposures and take the appropriate actions to minimize the likelihood of loss.

5. **Will there be other people who will make job site inspections?**
   Yes. The insurance company’s Risk Engineer may conduct periodic site inspections to verify compliance with State requirements. State, City and Federal inspectors may also make inspections.

**General Liability Insurance for Personal Injury, Bodily Injury and Property Damage Liability Questions**

What insurance company writes the Personal Injury, Bodily Injury, and Property Damage Liability coverage? Arch Insurance Company.

Is Completed Operations coverage provided beyond acceptance of the work performed under the Contract?

Yes. The extension for General Liability “completed operations” is for ten (10) years after Notice of Completion is filed by the Owner, or date Occupancy is taken.