STATE OF ALABAMA
WORKERS' COMPENSATION INFORMATION

000102 238/304 3 01

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER
Twin City Fire Insurance Company

TELEPHONE NUMBER (800) 327-3636

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE.

FOR INFORMATION CALL:
1-800-528-5166
Alabama Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131

CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

FORM WCC#1 10/12

Form WC 88 01 06 B Printed in U.S.A.

TO BE POSTED BY EMPLOYER **POLICY NUMBER** 10 WB AT1140

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

000102 239/304 3 01

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with:

Twin City Fire Insurance Company

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

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PARA SER COLOCADO POR EL PATRON **NUMERO DE POLIZA** 10 WB AT1140

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patron ha cumplido con las provisiones de la Ley de Compensacion para los Trabajadores de Arizona (Titulo 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las regias y ordenanzas de La Comision Industrial de Arizona hechas en cumplimiento de esta, y ha asegurado el pago de compensacion a los empleados garantizando el pago de dicha compensacion por medio de:

Twin City Fire Insurance Company

Ademas, a todos los empleados se les notifica por este medio que en caso de que especificadamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerara bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensacion bajo estos terminos; tambien bajo estos terminos los empleados tienen el derecho de rechazar la misma por medio de una notificacion por escrito antes de que sufran alguna lesion, todos los formularios o formas en blanco para tal notificacion por escrito estaran disponibles para todos los empleados en la oficina de este patron.

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KEEP POSTED IN A CONSPICUOUS PLACE.

COLOQUESE EN LUGAR VISIBLE.

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES
THIS NOTICE IS APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

ICA FORM 04-615-01
Form WC 88 02 04 B Printed in U.S.A.

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Síndrome de la Inmundeficiencia Adquirida (SIDA) y Hepatitis C

Se les notifica a los empleados que se puede hacer una reclamación por una condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIH), Síndrome de Inmunodeficiencia Adquirida (SIDA), o Hepatitis C bajo lo provisto por la Ley de Compensación para los Trabajadores de Arizona y las reglas de La Comisión Industrial de Arizona. Tal reclamación debe incluír el suceso de una exposición importante en el trabajo, la que por lo general significa contacto de alguna ruptura de la piel o mucosa del empleado con la sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido de una persona que contenga sangre. **EL EMPLEADO DEBE CONSULTAR A UN MEDICO PARA CONFIRMAR SU RECLAMACION.** Las reclamaciones no pueden resultar de actividad sexual o uso ilícito de drogas.

Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA O Hepatitis C si reúnen los requisitos siguientes:

1. El curso regular del empleo del empleado requiere el manejo de o la exposición a sangre, semen, fluido vaginal, fluido(s) quirúrgico(s) o cualquier otro fluido que contenga sangre. Incluídos en esta categoría son los proveedores de cuidados de la salud, trabajadores de laboratorios forenses, bomberos, agentes policiales, técnicos médicos de emergencia, paramédicos y agentes correccionales.

2. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una possible exposición importante que resulta de y en el curso de su trabajo, el empleado reporta a su patrón por escrito los detalles de la exposición como lo proveen las reglas de la Comisión. Las formas de reporte están disponibles en la oficina de este patrón o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 o 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. Si un empleado elige no llenar la forma de reporte, ese empleado corre el riesgo de perder una reclamación de prima facie.

3. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposción importante el empleado va a que le saquen sangre, y **NO MAS DE TREINTA (30) DIAS DE CALENDARIO** la sangre es analizada para **VIH O HEPATITIS C** por medio de análisis de anticuerpos y el análisis resulta negativo.

4. **NO MAS DE DIECIOCHO (18) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevemente y los resultados del análisis son positivos por VIH o el empleado ha sido diagnosticado como positivo por la presencia de VIH, o **NO MAS DE SIETE (7) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLADOS SOBRE COMPENSACION PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISION INDUSTRIAL
DE ARIZONA PARA USO DE LAS ASEGURADORAS

Este documento es una traduccion del texto original escrito en ingles. Esta traduccion no es oficial y no es vinculante para este estado o para una subdivision politica de este estado.

This document is a translation from original text written in English. This translation is unofficial and is not binding on this state or a political subdivision of this state.

ICA FORM 04-615-01
Form WC 88 02 05 B Printed in U.S.A.

WORK EXPOSURE TO METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA), SPINAL MENINGITIS, OR TUBERCULOSIS (TB)

Notice to Employees

000102 242/304 3 01

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;

2. No later than thirty (30) calendar days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;

3. A diagnosis is made within the following time-frames:

   a. For a claim involving MRSA, the employee must be diagnosed with MRSA within fifteen (15) days after the employee reports pursuant to Item No. 2 above;

   b. For a claim involving spinal meningitis, the employee must be diagnosed with spinal meningitis within two (2) to eighteen (18) days of the possible significant exposure; and

   c. For a claim involving TB, the employee is diagnosed with TB within twelve (12) weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

Employers must post this notice in a conspicuous place next to the Workers' Compensation Notice to Employees.

Form AR-P	ARKANSAS WORKERS' COMPENSATION COMMISSION	P
Ark. Code. Ann. §11-9-403, 407 AWCC Rule 7 Updated: 06-16-14	324 Spring Street, Little Rock, AR 72201 Mail: P.O. Box 950, Little Rock, AR 72203-0950 Little Rock Office - 1-800-622-4472 / 501-682-3930 Springdale Office - 1-800-852-5376 / 479-751-2790	

000102 243/304 3 01

WORKERS' COMPENSATION INSTRUCTIONS TO EMPLOYERS AND EMPLOYEES

All employees of this establishment entitled to benefits under the provisions of the Arkansas workers' compensation laws are hereby notified that their employer has secured the payment of such compensation as may at any time be due employees or their dependents. This employer is required by state law to provide workers' compensation coverage or this employer has waived the exclusion or exemption from the operation of the workers' compensation laws, and the employer certifies by the display of this poster that workers' compensation coverage is now provided by a workers' compensation insurance policy or by enrollment in the Arkansas Self-Insurance Program or by the Public Employee Claims Division of the Arkansas Insurance Department.

Twin City Fire Insurance Company
Northbelt II ? 785 Greens Pkwy, Ste 210
Houston TX 77067-4409
(800) 327-3636

Policy Expiration Date: 07/31/2022

IN CASE OF JOB-RELATED INJURIES OR OCCUPATIONAL DISEASES

The Employer Shall:

1. Provide all necessary medical, surgical and hospital treatment, as required by law, following the injury and for such additional time as ordered by the Workers' Compensation Commission.
2. Provide compensation payments in accordance with the provisions of the law. The first installment of compensation becomes due on the 15th day after the employer has notice of the injury or death, except in those cases where liability has been denied by the employer.
3. Provide prompt reporting of accidents to appropriate parties.
4. Keep a record of all injuries received by its employees.

The Employee Shall:

The employee shall report the injury to the employer on Form N and to a person or at a place specified by the employer, unless the injury either renders the employee physically or mentally unable to do so, or the injury is made known to the employer immediately after it occurs. The employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's notice of injury. All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements. The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

Failure to give such notice shall not bar any claim (1) if the employer had knowledge of the injury or death, (2) if the employee had no knowledge that the condition or disease arose out of and in the course of employment, or (3) if the Commission excuses such failure on the grounds that for some satisfactory reason such notice could not be given. Objection to failure to give notice must be made at or before the first hearing on the claim.

Statutory Information:

Ark. Code Ann. § 11-9-514(b) states "Treatment or services furnished or prescribed by any physician other than the ones selected according to the foregoing, except emergency treatment, shall be at the claimant's expense."

Ark. Code Ann. § 11-9-514(f), however, indicates: When compensability is controverted, subsection (b) shall not apply if:
(1) The employee requests medical assistance in writing prior to seeking the same as a result of an alleged compensable injury; and
(2) The employer refuses to refer the employee to a medical provider within forty-eight (48) hours after such written request as provided above; and
(3) The alleged injury is later found to be a compensable injury; and
(4) The employer has not made a previous offer of medical treatment.

If you have any questions regarding your rights under the Arkansas workers' compensation laws, you may call an Arkansas Workers' Compensation Commission legal advisor at our toll-free number listed above.

All employers who come within the operation of the Arkansas workers' compensation laws and have complied with its provisions must post this notice in a **CONSPICUOUS** place in or about their place or places of business.

AWCC Form P
(Posting Notice)

A posting notice is mentioned in **Ark. Code Ann. §11-9-403, Ark. Code Ann. §11-9-407** and **AWCC Rule 7. AWCC Form P** satisfies all requirements.

Form P:

1. Is to be on display in a conspicuous place;
2. Tells employers what to do when an employee is injured;
3. Instructs employees to notify the employer immediately (or no later than the close of the next business day) when injured;
4. Lists the claims office that will be handling the insurance aspects of the case;
5. Gives the claims office telephone number;
6. Announces the expiration date of the insurance policy; and
7. Provides telephone numbers for Arkansas Workers' Compensation Commission legal advisors if either party needs assistance.

Employers without **Form P** may lose the use of **Form N** as a defense in litigation. Employees disobeying instructions on **Form P** may delay their benefits or jeopardize the awarding of any benefits in a contested case.

The AWCC furnishes samples, not supplies, of **Form P**. Carriers are to send their insureds an adequate number, and self-insureds must arrange with a printer for the supply they need. Carriers and employers may enlarge **Form P** for posting purposes.

Information about Form P is available from the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under...this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

000102 244/304 3 01

Form ulario AR-P	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS	P
Autoridad: Ark. Code Ann., apartado 11-9-403, 407 AWCC, Norma 7 Actualizado: 06-16-2014 En Español: 10-15-2004	324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 Oficina de Little Rock: 1-800-622-4472 / 501-682-3930 Oficina de Springdale: 1-800-852-5376 / 479-751-2790	

000102 245/304 3 01

INSTRUCCIONES SOBRE LA COMPENSACIÓN DE LOS TRABAJADORES PARA EMPLEADORES Y EMPLEADOS

Todos los empleados de este centro que tengan derecho a beneficiales en virtud de lo dispuesto en la legislación de compensación de los trabajadores son informados en virtud del presente documento de que su empleador ha organizado el pago de las compensaciones que puedan tener que abonarse a los empleados o sus dependientes. Este empleador debe, en virtud de la legislación estatal, ofrecer a sus empleados cobertura por com pensaciones o ha renunciado a la exención o exclusión de la ejecución de la legislación en materia de compensaciones a los trabajadores y certifica mediante la muestra de este cartel que en la actualidad ofrece cobertura a sus trabajadores dentro de una póliza de seguro de compensación de los trabajadores o por su participación en el Programa de Auto-seguros de Arkansas o la División Pública de Reclamaciones de los Empleados del Departamento de Seguros de Arkansas.

Twin City Fire Insurance Company
Northbelt II ? 785 Greens Pkwy, Ste 210
Houston TX 77067-4409
(800)-327-3636
Fecha de Vencimiento de la Póliza: **07/31/22**

EN CASO DE PRODUCIRSE UNA LESIÓN VINCULADA AL TRABAJO O UNA ENFERMEDAD PROFESIONAL

El empleador deberá:

1. Ofrecer todo el tratamiento médico, quirúrgico y hospitalario que sea preciso en virtud de la legislación, tras la lesión y durante el tiempo adicional que establezca la Comisión de Compensación de los trabajadores.
2. Ofrecer pagos de compensación de acuerdo con lo dispuesto en la legislación. El primer plazo vencerá al cabo de 15 días desde que el empleador sea informado de la lesión o fallecimiento, excepto en los casos en el empleador haya denegado su responsabilidad.
3. Informar inmediatamente de los accidentes a los interesados.
4. Mantener un registro de todas las lesiones de las que sea informado por sus empleados.

El empleado deberá:

El empleado deberá informar de la lesión al empleador en el formulario N y a una persona o en un lugar indicado por este último, a menos que se trate de una lesión que impida mental o físicamente al empleado hacerlo o si la lesión se comunica al empleador inmediatamente después de producirse. El empleador no será responsable de las beneficiales de discapacidad, médicas o de otro tipo anteriores a la recepción del informe del accidente. Todos los procedimientos de notificación que especifique el empleador deberán ser razonables y éste deberá notificar razonablemente a todos los empleados los requisitos de notificación. Lo anterior no será de aplicación si el empleado precisa tratamiento médico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado deberá hacer que se notifique el accidente al empleador el siguiente día laborable habitual.

La falta de notificación no anulará las reclamaciones si: (1) El empleador tiene conocimiento del fallecimiento o lesión; o (2) El empleado no tenía conocimiento de que la afección o enfermedad se produjo en el transcurso de su empleo; o (3) La Comisión exime esta omisión basándose en que la notificación no pudo realizarse por un motivo justificado.
Las objeciones relativas a la falta de notificación deberán plantearse antes o en el momento de celebrarse la primera vista de la reclamación.

Información legal:

El artículo 11-9-514(b) del Ark. Code Ann. establece que: "El tratamiento o los servicios prestados por un médico distinto de los seleccionados de acuerdo con lo anterior, con excepción de los tratamientos urgentes, correrán a cargo del demandante."
El artículo 11-9-514(f) del Ark. Code Ann., sin embargo, establece que: Cuando la compensación sea causa de controversia, el subapartado (b) no será de aplicación si:
(1) El empleado solicita asistencia médica por escrito antes de buscarla como consecuencia de una posible lesión compensable; y
(2) El empleador se niega a remitir al empleado a un proveedor médico en el plazo de cuarenta y ocho (48) horas desde dicha solicitud escrita; y
(3) Posteriormente se descubre que la supuesta lesión es compensable; y
(4) El empleador no ha hecho ninguna oferta anterior de tratamiento médico.

Si tiene alguna pregunta relativa a sus derechos en virtud de la legislación en materia de compensaciones de los trabajadores de Arkansas, puede llamar al asesor legal de la Comisión de Compensación de los Trabajadores de Arkansas al número gratuito que se indica más arriba.

Todos los empleadores que se vean afectados por la ejecución de la legislación en materia de compensaciones de los trabajadores de Arkansas y que hayan cumplido estas disposiciones deberán colocar esta notificación en un lugar **PREEMINENTE** en su centro de trabajo o las cercanías.

Formulario P de la AWCC
(Notificación)

En los **apartados 11-9-403 y 11-9-407 del Ark. Code Ann. y la Regla 7 de la AWCC** se menciona una notificación. El **formulario P de la AWWC** cumple todos esos requisitos.

Formulario P:

1. Debe mostrarse en un lugar preeminente;
2. Dice a los empleados qué deben hacer cuando un trabajador se lesiona;
3. Instruye a los empleados para que notifiquen las lesiones inmediatamente al empleador (o no más tarde del final del siguiente día laborable);
4. Enumera la oficina de reclamaciones en la que se tratarán los aspectos vinculados a seguros del caso;
5. Anuncia la fecha en que expira la póliza de seguros;
6. Ofrece números de teléfono del asesor legal de la Comisión de Compensaciones de los Trabajadores de Arkansas por si alguien necesita ayuda.

Los empleadores que no cuenten con un **formulario P** podrán perder el derecho a utilizar el **formulario N** como defensa en un litigio. Los empleados que desobedezcan las instrucciones del **formulario P** podrán sufrir retrasos en el beneficio de cualquier prestación en los casos que se impugnen o corren el riesgo de perderlos.

La AWCC ofrece copias de muestra pero no suministra el **formulario P**. Las aseguradoras deben enviar a sus asegurados un número adecuado de copias y los auto-asegurados deben contratar el suministro con una imprenta. Las aseguradoras y los empleadores pueden ampliar el **formulario P** para publicarlo.

Puede obtenerse información sobre el formulario P de la División de Servicios de Soporte (1-800-622-4472 o 501-682-3930).

Ark. Code Ann., apartado 11-9-106(a): "Cualquier persona o entidad que realice consciente y voluntariamente una declaración o afirmación sustancial falsa o que omita u oculte consciente y voluntariamente un dato sustancial, o que utilice consciente y voluntariamente un dispositivo, sistema o artificio para: obtener una prestación o pago, engañar o aumentar o reducir ilegítimamente cualquier reclamación de beneficiales o pagos, u obtener o evitar la cobertura de compensación para los empleados o evitar el pago de la prima de seguro correspondiente, o que ayude e induzca a cualquiera de estos fines, será, en virtud del presente capítulo, culpable de un delito de Clase D. El cincuenta por ciento (50%) de cualquier multa penal impuesta y cobrada en virtud de... este artículo se pagará y adjudicará de acuerdo con la legislación aplicable al Fondo de Discapacidad Total Permanente y Fallecimiento administrado por la Comisión de Compensaciones de los Trabajadores."

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
División de Compensación de Trabajadores

Aviso a los Empleados - Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías, medicinas, equipo médico y costos de viajar que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay límites para visitas quiroprácticas, de terapia física y de terapia ocupacional.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible si su lesión surge en o después del 1/1/04, y su lesión le ocasiona una incapacidad permanente, y su empleador no le ofrece a usted un trabajo regular, modificado o alternativo.
- **Beneficios por Muerte:** Pagados a sus dependientes si usted muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, antes de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador o administrador de reclamos debe autorizar todo tratamiento médico, hasta diez mil dólares, de acuerdo con las pautas de tratamiento aplicables a su presunta lesión, hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad.
   - Si usted designó previamente a su médico personal o grupo médico, usted puede consultar a su médico personal o grupo médico después de lesionarse.
   - Si su empleador está utilizando una Red de Proveedores Médicos (MPN) o una Organización de Cuidado Médico (HCO), en la mayoría de los casos usted será tratado dentro de la MPN o la HCO a menos que usted designó previamente un médico personal o grupo médico. Una MPN es un grupo de médicos y proveedores de atención médica que proporcionan tratamiento a trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
4. Red de Proveedores Médicos (MPN): Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratamiento a los trabajadores lesionados en el trabajo. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información de contacto de la MPN:

Página web de la MPN: _____

Fecha de vigencia de la MPN: _____ Número de identificación de la MPN: _____

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: _____

Si usted tiene preguntas sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al:

_____

Discriminación: Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contratado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos Hartford Insurance Company of the Midwest Teléfono (800) 327-3636

Asegurador del Seguro de Compensación de trabajador Hartford Insurance Company of the Midwest (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores.

El Oficial de Información y Asistencia más cercano se localiza en: _____

o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "Compensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

DWC 7 (1/1/2016)
Form WC 88 04 00 I Printed in U.S.A.

STATE OF CALIFORNIA - DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

Notice to Employees - Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group before you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: _____

MPN Effective Date: _____ MPN Identification number: _____

If you need help locating an MPN physician, call your MPN access assistant at: _____

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at: _____

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

Questions? Learn more about workers' compensation by reading the information that you employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator Hartford Insurance Company of the Midwest Phone (800) 327-3636

Workers' compensation insurer Hartford Insurance Company of the Midwest (Enter "self-insured" if appropriate)

You can also get free information from a State Division of Workers' Compensation Information (DWC) & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401**. Learn more information about workers' compensation online: www.dwc.ca.gov and access a useful booklet "Workers' Compensation in California: A Guidebook for Injured Workers."

False claims and false denials. 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 and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

DWC 7 (6/10)
Form WC 88 04 01 I Printed in U.S.A.

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WORKERS' COMPENSATION - WRITTEN NOTICE TO NEW EMPLOYEES

This notice includes some of your rights, benefits and obligations under the workers' compensation law.

EVENTS, INJURIES AND ILLNESSES COVERED BY WORKERS' COMPENSATION

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over). You may not be entitled to workers' compensation benefits for any injury that arises from your voluntary participation in any off-duty, recreational, social or athletic activity that is not part of your work-related duties.

RIGHTS AND BENEFITS

You may have the right to the following:

- Medical Care Benefits which include: Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines as reasonably necessary to treat your injury.
- Temporary Disability (TD) Benefits: Payments if you lose wages while recovering. For most injuries that occur on or after Jan 1, 2008, temporary disability (TD) benefits may not extend for more than 104 compensable weeks within five years from the date of injury. For a few long term injuries, such as severe burns or chronic lung disease, benefits may not extend for more than 240 weeks within five years from the date of injury. Filing a timely Employment Development Department claim may result in additional state disability benefits when TD benefits terminate.
- Permanent Disability (PD) Benefits: Payments if your injury causes a permanent disability.
- Supplemental Job Displacement Benefits: A nontransferable voucher payable to a state approved school if you are injured on or after 1/1/04, the injury results in a permanent disability, you don't return to work within 60 days after TD ends, and your employer does not offer modified or alternative work.
- Death Benefits: Paid to dependents of a worker who dies from a work-related injury or illness.

Temporary disability, permanent disability, vocational rehabilitation maintenance allowance and death benefits are all payable based on 2/3 of your average weekly wage subject to state minimum and maximum rates in effect on your date of injury. Your benefits are paid every two weeks while you are eligible.

CHOOSING YOUR OWN DOCTOR

You may be able to choose the doctor who will treat you for a job injury or illness during the first 30 days after the injury. If eligible, you must tell your employer, in writing, the name and address of your personal physician **before** you are injured. You may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- **prior** to the injury your doctor agrees to treat you for work injuries or illnesses;
- **prior** to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

Pages 3 and 4 of this notice are forms which can be used for this purpose.

If you do not choose a doctor, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days, which may include your personal chiropractor or personal acupuncturist. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network (MPN).

Contact your employer for more information.

ROLE OF THE PRIMARY TREATING PHYSICIAN

Your Primary Treating Physician will decide what type of medical care you will receive for your injury or illness, determine when you can return to work, help identify the kinds of work you can do safely while recovering, refer you to specialists, if necessary, and write medical reports that will affect the benefits you receive. It is important to get good medical care to help you recover. You should be treated

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by a doctor who understands your particular type of injury or illness. Tell the doctor about your symptoms and the events at work that you believe caused them. Also, describe your job and your work environment.

IF YOU GET HURT – GET MEDICAL CARE. If you need first aid, contact your employer. If you need emergency medical treatment, call 911 or one of the numbers listed below. Tell the health care provide who treats you that your injury or illness is job related.

Ambulance _____

Fire Dept. _____

Police _____

Doctor _____

Hospital _____

REPORT YOUR INJURY OR ILLNESS

Report the injury immediately to your supervisor or to:

Employer Representative _____

Phone Number _____

Tell your supervisor right away. If your injury or illness developed gradually, report it as soon as you learn it was caused by your job. Reporting promptly helps prevent problems and delays in receiving benefits, including medical care you may need to avoid further injury. If your employer does not learn of your injury within 30 days, you could lose your right to receive workers' compensation benefits.

Your employer is required to provide you a claim form within one working day after learning about your injury. 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).

ADDITIONAL INFORMATION

You can get free information from a State of Workers' Compensation Information & Assistance Officer. To hear recorded information including a list of local offices, call toll-free (800) 736-7401. Learn more online: http://www.dir.ca.gov

The nearest Information & Assistance Officer is at:

Address _____

City _____

Phone _____

Your employer's compensation carrier at the time of your hire is:

Hartford Insurance Company of the Midwest

DISCRIMINATION

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

MEDICAL PROVIDER NETWORKS

Your employer may be using an MPN, which is a selected network of health care providers to provide treatment to workers injured on the job. If you have pre-designated a personal physician prior to your work injury, then you may receive treatment from your pre-designated doctor. If you have not pre-designated and your employer is using a MPN, you are free to choose an appropriate provider from the MPN list after the first medical visit directed by your employer. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. Contact your employer for more information.

False Claims and False Denials. Any person who makes or causes to be made any knowingly false of fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payment is guilty of a felony and may be fined and imprisoned.

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) or medical group if:

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related in injury or illness, and (2) your personal doctor's name and business address.

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You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work – related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ **(name of employer).** If I have a work-related injury or illness, I choose to be treated by:

_____

(name of doctor)(M.D., D.O., or medical group)

_____

_____

(street address, city, state, zip)

_____

(telephone number)

_____

Employee Name **(please print):** _____

_____

Employee's Address:

_____

Employee's Signature _____ **Date:** _____

Physician: I agree to this Predesignation:

Signature: _____ **Date:** _____

(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

_____

(name of chiropractor or acupuncturist)

_____

(street address, city, state, zip code)

_____

(telephone number)

Employee Name **(Please Print):**

_____

Employee's address:

_____

Employee's Signature _____ Date: _____

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SEGURO CONTRA ACCIDENTES LABORALES - NOTIFICACIÓN ESCRITA PARA NUEVOS EMPLEADOS

Esta notificación incluye algunos de sus derechos, beneficios y obligaciones según la ley del seguro contra accidentes laborales.

EVENTOS, LESIONES Y ENFERMEDADES CUBIERTOS POR EL SEGURO CONTRA ACCIDENTES LABORALES

Usted tendrá derecho a los beneficios del seguro contra accidentes laborales en caso de sufrir una lesión o contraer una enfermedad relacionada con su trabajo. El seguro contra accidentes laborales cubre gran parte de las enfermedades y lesiones físicas o mentales relacionadas con el trabajo. La lesión o enfermedad puede ser causada por un solo evento (como lesionarse la espalda en una caída) o por exposición reiterada (como lesionarse la muñeca por realizar un mismo movimiento repetidas veces). Usted no tendrá derecho a los beneficios del seguro contra accidentes laborales por una lesión que surja de la participación voluntaria en cualquier actividad fuera del trabajo, recreativa, social o deportiva, que no forme parte de sus obligaciones laborales.

DERECHOS Y BENEFICIOS

Usted podrá tener derecho a lo siguiente:

- Beneficios de atención médica que incluyen: consultas a médicos, servicios hospitalarios, fisioterapia, pruebas de laboratorio, radiografías y medicamentos que sean razonablemente necesarios para tratar la lesión.
- Beneficios por incapacidad temporal (TD): pagos en caso de perder el salario durante la recuperación. En la mayoría de las lesiones producidas después del 1 de enero de 2008 inclusive, los beneficios por incapacidad temporal (temporary disability, TD) no podrán extenderse por más de 104 semanas compensables en un plazo de cinco años a partir de la fecha de la lesión. Para algunas lesiones de largo plazo, tales como quemaduras graves o enfermedad pulmonar crónica, los beneficios no podrán extenderse por más de 240 semanas en un plazo de cinco años a partir de la fecha de la lesión. Cuando los beneficios por TD terminan, puede obtener beneficios por incapacidad adicionales del estado si presenta en forma oportuna una reclamación ante el Departamento de Desarrollo del Empleo.
- Beneficios por incapacidad permanente (PD): pagos cuando la lesión causa una incapacidad permanente.
- Beneficios complementarios por desplazamiento del trabajo: vale no transferible pagadero a una escuela autorizada por el estado por una lesión ocurrida después del 1/1/04 inclusive, cuando lesión causa una incapacidad permanente, usted no regresa al trabajo en el plazo de 60 días luego de finalizar la TD y su empleador no le ofrece un puesto de trabajo modificado o alternativo.
- Beneficios por fallecimiento: se pagan a los dependientes de un empleado que fallece a causa de una enfermedad o lesión relacionada con el trabajo.

Los beneficios por incapacidad temporal, incapacidad permanente, rehabilitación profesional, pensión alimenticia y fallecimiento se pagan sobre la base de 2/3 de su salario promedio semanal, sujeto a tasas máximas y mínimas, vigentes a la fecha de la lesión. Los beneficios se pagan cada dos semanas mientras usted sea elegible.

ELECCIÓN DEL MÉDICO PERSONAL

Usted podrá elegir el médico que tratará su enfermedad o lesión laboral durante los primeros 30 días posteriores a la lesión. Si es elegible, deberá informar por escrito el nombre y la dirección del médico personal a su empleador, **antes** de sufrir la lesión. Podrá ser tratado por dicha lesión o enfermedad por su médico personal (M.D.), osteópata (D.O.) o grupo médico si:

- su empleador ofrece cobertura médica colectiva;
- el médico es su médico habitual, quien deberá ser médico general o médico de familia, ginecólogo obstetra, pediatra o internista elegible por la junta médica o certificado por dicha junta, y que haya coordinado su tratamiento médico con anterioridad y conserve sus registros médicos;
- su "médico personal" puede ser un grupo médico si se trata de una única sociedad o asociación formada por médicos u osteópatas con licencia, que opera como un grupo médico integrado con múltiples especialidades, que brinda servicios médicos amplios, especialmente para lesiones y enfermedades no ocupacionales;
- **antes** de la lesión, el médico acepta tratarlo por enfermedades o lesiones laborales;
- **antes** de la lesión, usted suministra a su empleador lo siguiente por escrito: (1) notificación del deseo de que su médico personal lo trate por enfermedades o lesiones relacionadas con el trabajo, y (2) el nombre y la dirección comercial de su médico personal.

Para tal fin, puede utilizar los formularios de las páginas 3 y 4 de esta notificación.

Si no elige un médico, el empleador tendrá derecho a seleccionar el médico que lo tratará durante los primeros 30 días. Después de 30 días, usted podrá cambiar de médico según desee; este cambio podrá incluir a su

quiropráctico o acupunturista personal. Si su empleador ofrece una Organización de Atención Médica (Health Care Organization, HCO) o a partir del 1/1/05 tiene una red de proveedores de atención médica (medical provider network, MPN), se aplicarán normas especiales. Contacte a su empleador para obtener más información.

FUNCIÓN DEL MÉDICO DE ATENCIÓN PRIMARIA

El médico de atención primaria decidirá qué tipo de atención médica recibirá usted para su lesión o enfermedad, determinará cuándo podrá regresar a trabajar, contribuirá a identificar el tipo de tareas que puede realizar en forma segura durante la recuperación, lo referirá a especialistas, si es necesario, y escribirá informes médicos que afectarán los beneficios que usted reciba. Es importante obtener una buena atención médica para poder recuperarse. El médico que lo trate deberá conocer el tipo de lesión o enfermedad específica. Informe al médico sobre los síntomas y los eventos laborales que usted cree que los ocasionaron. También describa su trabajo y entorno laboral.

SI SE LESIONA, OBTENGA ATENCIÓN MÉDICA. Si necesita primeros auxilios, contacte a su empleador. Si necesita tratamiento médico de emergencia, llame al 911 o a uno de los números indicados debajo. Informe al proveedor de atención médica que la lesión o enfermedad está relacionada con su trabajo.

Ambulancia _____

Bomberos _____

Policía _____

Médico _____

Hospital _____

INFORMAR SOBRE LA LESIÓN O ENFERMEDAD

Informe de inmediato sobre la lesión a su supervisor o:

Representante del empleador _____

Número de teléfono _____

Hable con su supervisor de inmediato. Si la lesión o enfermedad se desarrolló en forma gradual, informe sobre esta tan pronto advierta que fue causada por su trabajo. Si se comunica de inmediato, evitará problemas y retrasos en la recepción de beneficios, incluida la atención médica necesaria para evitar lesiones mayores. Si el empleador no toma conocimiento de su lesión en un plazo de 30 días, usted puede perder el derecho a recibir los beneficios del seguro contra accidentes laborales.

El empleador deberá proporcionarle un formulario de reclamación en el plazo de un día laboral después de enterarse de la lesión. En el plazo de un día laboral tras la presentación del formulario de reclamación por parte del empleado, el empleador deberá autorizar la prestación del tratamiento, conforme a las pautas de tratamiento aplicables, para la supuesta lesión, y deberá continuar suministrando tratamiento hasta la fecha en que se acepte o rechace la responsabilidad por la reclamación. Hasta la fecha de rechazo o aceptación de la reclamación, la responsabilidad por el tratamiento médico se limitará a diez mil dólares ($10,000).

INFORMACIÓN ADICIONAL

Podrá obtener información gratuita a través de un Funcionario Estatal de Asistencia e Información sobre el Seguro contra Accidentes Laborales. Para escuchar información grabada, incluida una lista de oficinas locales, llame sin cargo al 1 (800) 736-7401. Información en línea: http://www.dir.ca.gov

Funcionario de Asistencia e Información más cercano se encuentra en:

Dirección _____

Ciudad _____

Teléfono _____

Compañía aseguradora contra accidentes laborales de su empleador al momento de su contratación:

Hartford Insurance Company of the Midwest

DISCRIMINACIÓN

La sanción o despido por sufrir una enfermedad o lesión laboral, presentar una reclamación o testificar en un caso de seguro contra accidentes laborales de otra persona, constituye un acto ilegal por parte del empleador. Si esto se demuestra, usted podrá recibir salarios perdidos, reincorporación al trabajo, aumento en los beneficios, más costos y gastos hasta el límite establecido por el estado.

RED DE PROVEEDORES MÉDICOS (MPN)

Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación hablando al número de la MPN debajo descrito. Si usted ha hecho una designación previa de un médico personal antes de leionarse en el trabajo, entonces usted puede recibir tratamiento de su medico previamente designado. Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede esoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Contacte a su empleador para obtener más informatión.

Reclamaciones y negaciones falsas. Toda persona que realice o motive una declaración o manifestación sustancial falsa o fraudulenta en forma intencional, con el fin de obtener o negar el pago o los beneficios del seguro contra accidentes laborales, será culpable de delito grave y quedará sujeta a la pena de multa o prisión.

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DESIGNACIÓN PREVIA DE MÉDICO PERSONAL

En caso de sufrir una lesión o enfermedad relacionada con su trabajo, podrá ser tratado para dicha lesión o enfermedad por su médico personal (M.D.), osteópata (D.O.) o grupo médico si:

- su empleador ofrece cobertura médica colectiva;
- el médico es su médico habitual, quien deberá ser médico general o médico de familia, ginecólogo obstetra, pediatra o internista elegible por la junta médica o certificado por dicha junta, y que haya coordinado su tratamiento médico con anterioridad y conserve sus registros médicos;
- su "médico personal" puede ser un grupo médico si se trata de una única sociedad o asociación formada por médicos u osteópatas con licencia, que opera como un grupo médico integrado con múltiples especialidades, que brinda servicios médicos amplios, especialmente para lesiones y enfermedades no ocupacionales;
- antes de la lesión, el médico acepta tratarlo por enfermedades o lesiones laborales;
- antes de la lesión, usted suministra al empleador lo siguiente por escrito: (1) notificación del deseo de que su médico personal lo trate por enfermedades o lesiones relacionadas con el trabajo, y (2) el nombre y la dirección comercial de su médico personal.

Si cumple con los requisitos anteriores y desea que su médico u osteópata personal lo trate por una lesión o enfermedad relacionada con el trabajo, podrá usar el siguiente formulario para notificar a su empleador.

NOTIFICACIÓN DE DESIGNACIÓN PREVIA DE MÉDICO PERSONAL

Empleado: complete esta sección.

Para: _____ **(nombre del empleador)**. Si sufro una lesión o enfermedad relacionada con mi trabajo, elijo ser tratado por:

_____

(nombre del médico) (M.D., D.O. o grupo médico)

_____

(dirección, ciudad, estado, código postal)

_____

(número de teléfono)

Nombre del empleado **(en letra de imprenta):**

Dirección del empleado:

Firma del empleado _____ **Fecha:** _____

Médico: acepto esta designación previa:

Firma: _____ **Fecha:** _____

(Médico o empleado designado del médico o grupo médico)

No es obligatorio que el médico firme este formulario; no obstante, si el médico o empleado designado del médico o el grupo médico no lo firma, se exigirá otra documentación en la que conste la aceptación del médico a ser designado previamente conforme al Título 8 del Código de Reglamentaciones de California, sección 9780.1(a)(3).

Título 8 del Código de Reglamentaciones de California, sección 9783.

NOTIFICACIÓN DE QUIROPRÁCTICO O ACUPUNTURISTA PERSONAL

Si su empleador o la compañía aseguradora de su empleador no tienen una Red de Proveedores de Atención Médica, usted podrá cambiar el médico que lo trata por su quiropráctico o acupunturista personal tras una lesión o enfermedad relacionada con el trabajo. A fin de ser elegible para realizar este cambio, deberá informar por escrito a su empleador el nombre y la dirección comercial del quiropráctico o acupunturista personal, antes de la lesión o enfermedad. Por lo general, el administrador de reclamaciones tiene derecho a seleccionar el médico que lo trata durante los primeros 30 días después de que el empleador se entere de la lesión o enfermedad. Después de que el administrador de reclamaciones inicie el tratamiento con otro médico durante dicho período, usted podrá solicitar que el tratamiento se transfiera a su quiropráctico o acupunturista personal.

Para notificar al empleador sobre su quiropráctico o acupunturista personal, puede usar el siguiente formulario.

Información del quiropráctico o acupunturista:

_____

(nombre del quiropráctico o acupunturista)

_____

(dirección, ciudad, estado, código postal)

_____

(número de teléfono)

Nombre del empleado **(en letra de imprenta):**

_____

Dirección del empleado:

_____

Firma del empleado _____ Fecha: _____

Important Information about Medical Care if you have a Work-Related Injury or Illness Complete Written MPN Employee Notification

(Title 8, California Code of Regulations, section 9767.12)

California law requires your employer to provide and pay for medical treatment if you are injured at work. Your employer has chosen to provide this medical care by using a Workers' Compensation physician network called a Medical Provider Network ("MPN"). The claims for this MPN are administered by Hartford Fire Insurance Company. This notification tells you what you need to know about the MPN program and describes your rights in choosing medical care for work-related injuries and illnesses.

o What happens if I get injured at work?

In case of an emergency, you should call 911 or go to the closet emergency room.

If you are injured at work, notify your employer as soon as possible. Your employer will provide you with a claim form. When you notify your employer that you have had a work-related injury, your employer or insurer will make an initial appointment with a doctor in the MPN.

o What is a MPN?

A Medical Provider Network (MPN) is a group of health care providers (physicians and other medical providers) used by your employer to treat workers injured on the job. Each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine.

MPNs must allow employees to have a choice of provider(s).

o What MPN is used by my employer?

You must refer to the MPN name and the MPN identification number whenever you have questions or requests about the MPN. Your employer is using The Hartford Select Network MPN with the MPN identification number 3044.

General information regarding the MPN can also be found at the following website: The MPN informational website address is: https://www.thehartford.com/ca-workers-compensation.

o How do I find out which doctors are in my MPN?

First, you could access the Provider Directory as set out below. Alternative resources are available as follows: by calling your Claim Handler, the Network Referral Unit, or the Medical Access Assistant also set out below under Provider Directories. A roster of all treating physicians in the MPN is available at http://www.thehartfordselectnetworkmpn.com/.

The MPN contact listed in this notification will be able to answer your questions about the MPN and will help you obtain a regional list of all MPN doctors in your area. At minimum, the regional listing must include a list of all MPN providers within fifteen (15) miles of your workplace and/or residence or a list of all MPN providers within the county where you live and/or work. You may choose which list you wish to receive.

You can get the list of MPN providers by calling the MPN Contact. Or, you may contact The Hartford to locate a participating provider or obtain a regional listing as follows:

Provider Directories:

On-line Directories – if you have internet access, you may obtain a regional directory or locate a participating provider near you by visiting http://www.thehartfordselectnetworkmpn.com/.

If you do not have internet access, you may request assistance in locating an MPN provider or obtaining a regional listing by calling:

- Your Claim Handler @ 866.401.9222, or
- The Network Referral Unit at 1.800.327.3636, prompt 4, or
  The Medical Access Assistant @ 866-758-7256.

Statewide Treating Provider List:

You also have the right to a complete listing of all of the MPN providers upon request. You may generate the list yourself via the internet, go to http://www.thehartfordselectnetworkmpn.com/.

If you need assistance with finding an available MPN provider, or would like help in scheduling and confirming provider appointments, our MPN Medical Access Assistant can be reached, toll free, at 866-758-7256, 7 am – 8 pm Pacific Time (Monday – Saturday) (excluding Sundays and holidays); by fax at 916-293-5025; or by email at thehartfordmaa@primehealthservices.com. At least one MPN Medical Access Assistant is available to respond at all required times, with the ability for callers to leave a voice message. Medical Access Assistants will respond to calls, faxes or messages by the next day, excluding Sundays and holidays. Medical Access Assistants work in coordination with the MPN Contact and the Claim Handler(s) to ensure timely and appropriate medical treatment is available to you, the injured worker. Assistance provided by the Medical Access Assistants is available in English and Spanish.

- **How do I choose a provider?**

Your employer or the insurer for your employer will arrange the initial medical evaluation with a MPN physician. After the first medical visit, you may continue to be treated by that doctor, or you may choose another doctor from the MPN. You may continue to choose doctors within the MPN for all of your medical care for this injury.

If appropriate, you may choose a specialist or ask your treating doctor for a referral to a specialist. Some specialists will only accept appointments with a referral from the treating doctor. Such specialist might be listed as "by referral only" in your MPN directory.

If you need help in finding a doctor or scheduling a medical appointment, you may call the Medical Access Assistant.

- **Can I change providers?**

Yes. You can change providers within the MPN for any reason, but the providers you choose should be appropriate to treat your injury. Contact your MPN Contact or your Claim Handler if you want to change your treating physician.

- **What standards does the MPN have to meet?**

The MPN has providers for the entire state of California.

The MPN must give you a regional list of providers that includes at least three available physicians of each specialty to treat common injuries based on your occupation or industry. The MPN must have at least three available primary treating physicians and a hospital or emergency healthcare service provider within fifteen (15) miles or thirty (30) minutes of your residence or workplace. The MPN must have providers of occupational health services and specialists within thirty (30) miles or sixty (60) minutes of your residence or workplace.

The MPN must provide initial treatment within three (3) days. You must receive specialist treatment within twenty (20) business days of your request for an appointment through an MPN Medical Access Assistant. If an MPN Medical Access Assistant is unable to schedule a timely medical appointment (i.e. scheduled within twenty (20) business days) with an appropriate specialist within ten (10) business days of an employee's request, the employer shall permit the employee to obtain necessary treatment with an appropriate specialist outside of the MPN. If you have trouble getting an appointment, contact the Medical Access Assistant.

If there are no MPN providers in the appropriate specialty available to treat your injury within the distance and timeframe requirements, then you will be allowed to seek the necessary treatment outside of the MPN.

- **What if there are no MPN providers where I am located?**

If you are a current employee:

- living in a rural area or temporarily working or living outside the MPN service area, or
- you are a former employee permanently living outside the MPN service area, or
- you are an injured worker who decides to temporarily reside outside the MPN service area during recovery,

Your Claim Handler, the MPN, or your treating doctor will give you a list of at least three physicians who can treat you. Your Claim Handler may also allow you to choose your own doctor outside of the MPN network.

- **What if I need a specialist not in the MPN?**

If you need to see a type of specialist that is not available in the MPN, you have the right to see a specialist outside of the MPN.

- **What if I disagree with my doctor about medical treatment?**

If you disagree with your doctor or wish to change your doctor for any reason, you may choose another doctor within the MPN.

If you disagree with either the diagnosis or treatment prescribed by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact the MPN Contact or your Claim Handler and tell them you want a second opinion. The MPN should give you at least a regional MPN provider list from which you can choose a second opinion doctor. To get a second opinion, you must choose a doctor from the MPN list and make an appointment within sixty (60) days. You must tell your Claim Handler of your appointment date, and your Claim Handler will send the doctor a copy of your medical records. You can request a copy of your medical records that will be sent to the doctor.

If you do not make an appointment within sixty (60) days of receiving the regional provider list, you will not be allowed to have a second or third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If the second opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you. You will get another list of MPN doctors or specialists so you can make another selection.

If you disagree with the second opinion, you may ask for a third opinion. If you request a third opinion, you will go through the same process you went through for the second opinion.

Remember that if you do not make an appointment within sixty (60) days of obtaining another MPN provider list, then you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If you disagree with the third opinion doctor, you may ask for an MPN Independent Medical Review (IMR). Your employer or MPN contact person will give you information on requesting an Independent Medical Review and a form at the time you request a third opinion.

If either the second or third opinion doctor agrees with your need for a treatment or test, you will be allowed to receive that medical service from a provider inside the MPN, or if the MPN does not contain a physician who can provide the recommended treatment, you may choose a physician outside the MPN within a reasonable geographic area.

If the Independent Medical Reviewer supports your need for a treatment or test you may receive that care from a doctor inside or outside of the MPN.

- **What if I am already being treated for a work-related injury before the MPN begins?**

Your employer or insurer has a *"Transfer of Care"* policy which will determine if you can continue being temporarily treated for an existing work-related injury by a physician outside of the MPN before your care is transferred into the MPN.

If you have properly pre-designated a primary treating physician, you cannot be transferred into the MPN. (If you have questions about pre-designation, ask your supervisor.) If your current doctor is not or does not become a member of the MPN, then you may be required to see a MPN physician.

If your employer decides to transfer you into the MPN, you and your primary treating physician must receive a letter notifying you of the transfer.

If you meet certain conditions, you may qualify to continue treating with a non-MPN physician for up to a year before you are transferred into the MPN. The qualifying conditions to postpone the transfer of your care into the MPN are in the box below.

Can I Continue Being Treated By My Doctor?

You may qualify for continuing treatment with your non-MPN provider (through transfer of care or continuity of care) for up to a year if your injury or illness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed in less than 90 days;
- **(Serious or chronic)** Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date, or the termination of contract date between the MPN and your doctor.

You can disagree with your employer's decision to transfer your care into the MPN. If you don't want to be transferred into the MPN, ask your primary treating physician for a medical report on whether you have one of the four conditions stated above to qualify for a postponement of your transfer into the MPN.

Your primary treating physician has twenty (20) days from the date of your request to give you a copy of his/her report on your condition. If your primary treating physician does not give you the report within twenty (20) days of your request, the employer can transfer your care into the MPN and you will be required to use a MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the transfer of your care. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete transfer of care policy for more details on the dispute resolution process.

For a copy of the entire transfer of care policy in either English or Spanish, ask your MPN Contact.

- **What if I am being treated by a MPN doctor who decides to leave the MPN?**

Your employer or insurer has a written *"Continuity of Care"* policy that will determine whether you can temporarily continue treatment for an existing work injury with your doctor if your doctor is no longer participating in the MPN.

If your employer decides that you do not qualify to continuing your care with the non-MPN provider, you and your primary treating physician must receive a letter notifying you of this decision.

If you meet certain conditions, you may qualify to continue treating with this doctor for up to a year before you must switch to MPN physicians. These conditions are set forth in the box above, ***"Can I Continue Being Treated By My Doctor?"***

You can disagree with your employer's decision to deny you Continuity of Care with the terminated MPN provider. If you want to continue treating with the terminated doctor, ask your primary treating physician for a medical report on whether you have one of the four conditions stated in the box above to see if you qualify to continue treating with your current doctor temporarily.

Your primary treating physician has twenty (20) days from the date of your request to give you a copy of his/her medical report on your condition. If your primary treating physician does not give you the report within twenty (20) days of your request, your employer's decision to deny you Continuity of Care with your doctor who is no longer participating in the MPN will apply, and you will be required to choose a MPN physician.

You will need to give a copy of the report to your employer or Claim Handler if you wish to postpone the selection of another MPN doctor for your continued treatment. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Continuity of Care policy for more details on the dispute resolution process.

For a copy of the entire Continuity of Care policy in either English or Spanish, ask your MPN Contact.

- **Who do I contact if I have questions about my MPN?**

  - **MPN Contact:** You may always contact the MPN Contact or Claim Handler assigned to your case, if you need help or an explanation about your medical treatment for your work-related injury or illness at:

    P.O. Box 14475, Lexington, KY 40512
    Toll-free Telephone Number for Claim Handler: 866.401.9222
    Toll-free Telephone Number of MPN Contact: 866.401.9222, x2304195
    Toll-free Telephone Number of Network Referral Unit for a list of MPN providers and/or MPN Pharmacies: 1.800.327.3636, prompt 4
    E-Mailbox: CAMPN.Claim@thehartford.com

    If you have questions concerning your:
    1) medical prescriptions, or
    2) physical therapy, occupational therapy, work hardening or chiropractic services need for your work-related injury or illness, please contact your Claim Handler at 866.401.9222.

    If you have a complaint about the MPN, please contact your MPN Contact.

  - **MPN Medical Access Assistant (MAAs):**

    If you need assistance with finding an available MPN provider, or would like help in scheduling and confirming provider appointments, our Medical Provider Network Medical Access Assistants can be reached, toll free, at 866-758-7256, 7 am – 8 pm Pacific Time (Monday – Saturday) (excluding Sundays and holidays); by fax at 916-293-5025; or by email at: TheHartfordMAA@Primehealthservices.com. At least one MPN Medical Access Assistant is available to respond at all required times, with the ability for callers to leave a voice message. Medical Access Assistants will respond to calls, faxes or messages by the next day, excluding Sundays and holidays. Medical Access Assistants work in coordination with the MPN Contact and the Claim Handler(s) to ensure timely and appropriate medical treatment is available to you, the injured worker. Assistance provided by the Medical Access Assistants is available in English and Spanish.

Division of Workers' Compensation (DWC): If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment after a work-related injury or illness, you can call DWC's Information and Assistance at 1.800.736.7401. You can also go to DWC's website at www.dir.ca.gov/dwc and click on "medical provider networks" for more

- information about MPNs.

- **Independent Medical Review**: If you have questions about the Independent Medical Review process contact the Division of Workers' Compensation's Medical Unit at:

  DWC Medical Unit
  P.O. Box 71010
  Oakland, CA 94612
  510.286.3700 or 800.794.6900

Keep this information in case you have a work-related injury or illness.

(Español)

Información Importante sobre Cuidado Médico si tiene una Lesión o Enfermedad de Trabajo.

Notificación Completa Escrita del Empleado sobre la Red de Proveedores Médicos

(Título 8, Código de Regulaciones de California, sección 9767.12)

La ley de California requiere que su empleador le proporcione y pague el tratamiento médico si se lesiona en el trabajo. Su empleador ha elegido a proveer este cuidado médico utilizando una red de médicos de Compensación de Trabajadores llamada Red de Proveedores Médicos o MPN (Medical Provider Network). Esta MPN está administrada por Hartford Fire Insurance Company. Esta notificación le informará lo que necesita saber sobre el programa de la MPN y le describirá sus derechos en elegir cuidado médico para sus lesiones o enfermedades de trabajo.

o ¿Qué pasa si me lastimo en el trabajo?

En caso de emergencia, debe llamar al 911 o ir a la sala de emergencias más cercana.
Si se lesiona en el trabajo, notifique a su empleador lo más pronto posible. Su empleador le proporcionará un formulario de reclamo. Cuando le notifique a su empleador que ha sufrido una lesión de trabajo, su empleador hará la cita inicial con el médico de la MPN.

o ¿Qué es una MPN?

Una Red de Proveedores Médicos o MPN es un grupo de proveedores de asistencia médica (médicos y otros proveedores médicos) utilizados por su empleador para atender a trabajadores que se lesionan en el trabajo. Cada MPN debe incluir una combinación de médicos que se especializan en lesiones de trabajo y médicos expertos en áreas de medicina general.

Las MPN deben permitir que los empleados tengan una selección de proveedor(es).

o ¿Qué MPN utiliza mi empleador?

Debe consultar el nombre de la MPN y el número de identificación de la MPN siempre que desee realizar preguntas o solicitudes relacionadas con la MPN. Su empleador utiliza la MPN The Hartford Select Network y el número de identification # 3044.

Para obtener información general relacionada con la MPN, también puede visitar la siguiente página web: La dirección de la página web informativa de la MPN es: https://www.thehartford.com/ca-workers-compensation.

o ¿Cómo puedo averiguar cuáles médicos pertenecen a mi MPN?

En primer lugar, puede acceder a los Directorios de Proveedores tal como se explica debajo. Los siguientes son recursos alternativos: llamar a su gestor de reclamo, a la Unidad de Referencia de la R o al Asistente de Acceso Médico, también indicado debajo bajo los Directorios de proveedores. Una lista de todos los médicos tratante de la MPN está disponible en http://www.thehartfordselectnetworkmpn.com/ y haga clic en la lista de la MPN de CA de la ficha de tratamiento los médicos.

El contacto de la MPN indicado en esta notificación podrá contestarle sus preguntas sobre la MPN y le ayudará a obtener una lista regional de los médicos de la MPN en su área. Como mínimo, la lista regional debe incluir una lista de todos los proveedores de la MPN dentro de quince (15) millas de su lugar de trabajo y/o residencia o una lista de todos los proveedores de la MPN dentro del condado donde usted vive y/o trabaja. Usted puede elegir cual lista quiere recibir.

Puede obtener la lista de los proveedores de la MPN llamando al contacto de la MPN. Para ubicar a un proveedor participante u obtener un directorio regional.

Directorios de proveedores médicos:

- Directorios en línea. Si tiene acceso a Internet puede obtender un directorio regional o localizar a un proveedor participante cerca de usted, visitando http://www.thehartfordselectnetworkmpn.com/.
- Si no dispone de acceso a Internet, puede pedir asistencia para localizar un proveedor de MPN u obtender un listado regional llamando a:
  - su Gestor de reclamos al 866.401.9222,
  - la Unidad de la Red de Referencia al 1.800.327.3636, selección 4, o bien
  - Su Asistente de Acceso Médico al 866-758-7256.

Lista de proveedores de todo el estado:

Usted también tiene derecho a recibir un listado completo de todos los proveedores de la red de proveedores de atención médica (Medical Provider List Network, MPN) a solicitud. Podrá generar la lista usted mismo a través de internet de la siguiente manera.

Vaya a http://www.thehartfordselectnetwork.mpn.com/.

También tiene derecho a una lista completa de todos los proveedores de la MPN, si la pide. Si necesita asistencia para encontrar a un proveedor MPN disponible, o desea obtener ayuda para obtener una cita, puede contactar a nuestro Asistente de Acceso Médico sin cargo al 866-758-7256 de 7 a.m. a 8 p.m. Pacifico (lunes a sábado) (excepto domingos y feriados); por fax al 916-293-5025; o por correo electrónico a thehartfordmaa@primehealthservices.com. Al menos un Asistente de Acceso Médico está disponible para responder en todos los momentos solicitados, pudiendo las personas que llaman dejar un mensaje de voz. Los Asistentes de Acceso Médico responderán los llamados, faxes o mensajes antes del día siguiente, excepto domingos y feriados. Los Asistentes de Acceso Médico trabajan en conjunto con el Contacto MPN y el(los) Gestor(es) de reclamos para asegurarse de que usted, el trabajador lesionado, tenga tratamiento médico adecuado a tiempo. Asistencia prestada por los médicos asistentes de acceso está disponible en inglés y español.

Errores en listados de proveedores

Los errores en cualquier dato de proveedores pueden informarse a las redes médicas directamente utilizando la función Notification (Notificación) en la página de resultados o enviando un correo electrónico a la siguiente dirección de correo electrónico de The Hartford: CAMPN.Claim@thehartford.com; o bien, llamando al número gratuito 866.401.9222.

Pasos de la función Notification (Notificación):

- En el encabezado Notification (Notificación),
- Haga clic en Notify Provider Status Change (Notificar cambio de estado de proveedor),
- Aparece la pantalla Provider Letter (Carta de proveedor),
- Complete con la información correspondiente,
- Haga clic en el botón Create Request (Crear solicitud) en la parte inferior de la pantalla.

- **¿Cómo escojo un proveedor?**

Después de la primera visita médica, puede continuar ser atendido por este médico o puede elegir otro médico dentro de la MPN. Puede continuar eligiendo médicos de la MPN para todo su cuidado médico para esta lesión. Si es apropiado, puede escoger un especialista o puede pedirle al médico que lo está atendiendo que lo refiera a un especialista. Si necesita ayuda para eligir un médico puede llamar al Asistente de Acceso Médico arriba descrito. Puede haber limitaciones con respecto a los quiroprácticos seleccionados como médicos tratantes, tales como límite de veinte y cuatro (24) visitas, a menos que el empleador o la aseguradora autoricen lo contrario.

- **¿Puedo cambiar de proveedor?**

Sí. Usted puede cambiar de proveedores dentro de la MPN por cualquier razón, pero los proveedores que elija deben ser apropiados para tratar su lesión.

- **¿Qué requisitos debe tener la MPN?**

La MPN tiene proveedores para todo el estado de California.

La MPN tiene que proporcionarle una lista regional de proveedores que incluya por lo menos tres médicos disponibles en cada especialidad usualmente utilizada para tratar lesiones/enfermedades en su industria u ocupación. La MPN debe tener al menos tres médicos tratantes primarios y un hospital o proveedor de servicios de emergencia dentro de las quince (15) millas o treinta (30) minutos de su residencia o lugar de trabajo. La MPN debe tener proveedores de servicios de medicina laboral y especialistas dentro de las treinta (30) millas o sesenta (60) minutos de su residencia o lugar de trabajo.

La MPN debe proporcionarle tratamiento inicial dentro de tres (3) días. Debe recibir tratamiento del especialista dentro de veinte (20) días hábiles de su petición de una cita a través del Asistente de Acceso Médico de la MPN. Si un Asistente de Acceso Médico no puede programar una cita médica a tiempo (es decir, programada dentro de los veinte (20) días hábiles) con un especialista adecuado dentro de los diez (10) días hábiles desde la solcitud del empleador, el empleador permitirá al empleado obtener el tratamiento necesario con un especialista adecuado por fuera de la MPN. Si tiene algún problema en obtener una cita, póngase en contacto con el Asistente de Acceso Médico.

Si no hay proveedores de la MPN de la especialidad apropiada disponible para tartar su lesión dentro de los requisitos de distancia y tiempo, entonces podrá buscar el necesario tratamiento fuera del MPN.

- **¿Qué tal si no hay proveedores de la MPN donde estoy localizado?**

Si es un empleado actual:

- que vive en un área rural, o temporalmente está trabajando o viviendo fuera del área de servicio de la MPN, o
- es un ex empleado viviendo permanentemente fuera del área de servicio de la MPN, o
- es un trabajador lesionado que decide residir temporalmente fuera del área de servico de la MPN durante su recuperación, su gestor de reclamos, la MPN o el médico que lo está atendiendo le dará una lista de por lo menos tres médicos que lo puedan atender. Su Gestor de reclamos también puede permitirle elegir su propio médico fuera de la red de la MPN.

- **¿Qué tal si necesito un especialista que no está dentro de la MPN?**

Si necesita ver un especialista que no está disponible dentro de la MPN, usted tiene derecho a ver un especialista fuera de la MPN.

- **¿Qué tal si no estoy de acuerdo con mi médico sobre tratamiento médico?**

Si usted no está de acuerdo con su médico o desea cambiar de médico por cualquier razón, usted puede escoger otro médico dentro de la MPN.

Si usted no está de acuerdo con el *diagnóstico o tratamiento* recetado por su médico, usted puede pedir una segunda opinión de un médico dentro de la MPN. Si quiere una segunda opinión, debe ponerse en contacto con la MPN o el su Gestor de reclamos y decirles que quiere una segunda opinión. La MPN debe proporcionarle por lo menos una lista regional de proveedores de la MPN para elegirlo. Para obtener una segunda opinión, debe elegir un médico dentro de la lista de la MPN y hacer una cita dentro de sesenta (60) días. Usted debe decirle a su Gestor de reclamos la fecha de su cita y su Gestor de reclamos le mandará al médico una copia de su expediente médico. Usted puede pedir una copia de su expediente médico que se le enviará al médico.

Si no hace una cita dentro de sesenta (60) días a partir de que recibe la lista regional de proveedores, no le será permitido tener una segunda o tercera opinión sobre el diagnóstico o tratamiento disputado recomendado por el médico que lo está atendiendo.

Si el médico de la segunda opinión siente que su lesión está fuera del tipo de lesión que él o ella normalmente trata, la oficina del médico le notificará a su empleador o compañía de seguros y a usted. Además obtendrá otra lista de médicos o especialistas de la MPN para que pueda hacer otra selección.

Si usted no está de acuerdo con la segunda opinión, puede pedir por una tercera opinión. Si usted pide una tercera opinión, usted pasará por el mismo proceso que pasó para la segunda opinión.

Recuerde que si no hace una cita dentro de sesenta (60) días a partir de recibir la otra lista de proveedores de la MPN, entonces no le será permitido tener una tercera opinión sobre el diagnóstico o tratamiento disputado recomendado por el médico que lo está atendiendo.

Si usted no está de acuerdo con el médico de la tercera opinión, usted puede pedir una Revisión Médica Independiente o IMR (Independent Medical Review). Su empleador o la persona de contacto de la MPN le darán información sobre cómo pedir la Revisión Médica Independiente y un formulario cuando usted pida la tercera opinión.

Si el médico de la segunda o tercera opinión está de acuerdo que usted necesita algún tratamiento o análisis, le será permitido recibir el servicio médico de un proveedor dentro de la MPN, o si la MPN no incluye un médico que pueda proporcionarle el tratamiento recomendado, usted puede elegir a un médico fuera de la MPN dentro de un área geográfica razonable.

Si el médico que hace la Revisión Médica Independiente corrobora su necesidad para algún tratamiento o análisis, usted podrá recibir ese cuidado de un médico dentro o fuera de la MPN.

- **¿Qué tal si ya estoy siendo atendido por una lesión de trabajo antes de que empiece la MPN?**

Su empleador o la compañía de seguros tienen un plan de "Transferencia de Cuidado" que determinará si usted puede continuar siendo temporalmente atendido por una lesión de trabajo existente por un médico fuera de la MPN antes de que su cuidado sea transferido a la MPN.

Si usted ha designado previamente un médico para atenderlo de manera apropiada, usted no puede ser transferido a la MPN. (Si tiene preguntas acerca de la designación previa, pregúntele a su supervisor.) Si su médico actual no es o no se convierte en un miembro de la MPN, entonces podrá ser obligado ver a un médico de la MPN.

Si su empleador decide tranferirlo a la MPN, usted y su médico que lo está atendiendo deben recibir una carta notificándoles de la tranferencia.

Si usted cumple con ciertos requistos, pueda que califique a continuar ser atendido por un médico fuera de la MPN hasta por un año antes de que sea transferido a la MPN. Los requisitos para posponer la tranferencia de su cuidado a la MPN están en el recuadro debajo.

¿Puedo continuar siendo tratado por mi médico?

Usted puede calificar para tratamiento continuo con su proveedor que no está dentro de la MPN (por tranferencia de cuidado o continuidad de cuidado) hasta por un año si su lesión o enfermedad cumple con cualquiera de las siguentes condiciones:

- **(Agudo)** El tratamiento para su lesión o enfermedad será completado en menos de 90 días;
- **(Grave o crónico)** Su lesión o enfermedad es una que es grave y continúa por lo menos 90 días sin una cura total o empeora y requiere de tratamiento continuo. Se le podrá permitir ser tratado por su médico actual hasta por un año, hasta que una tranferencia de cuidado segura pueda ser hecha.
- **(Terminal)** Tiene una enfermedad incurable o condición irreversible que probablemente cause la muerte dentro de un año o menos.
- **(Cirugía pendiente)** Ya tiene una cirugía u otro procedimiento que ha sido autorizado por su empleador o compañía de seguros y que se realizará dentro de 180 días a partir de la fecha efectiva de la MPN o la fecha de la terminación del contrato entre la MPN y su médico.

Usted puede no estar de acuerdo con la decisión de su empleador sobre transferir su cuidado a la MPN. Si no quiere ser transferido a la MPN, pídale a su médico de atención primaria un informe médico que indique si tiene una de las cuatro condiciones indicadas arriba para poder posponer su transferencia a la MPN.

El médico que lo está atendiendo tiene veinte (20) días a partir de la fecha de su petición para darle una copia del informe sobre su condición. Si el médico que lo está atendiendo no le da el informe dentro de los veinte (20) días a partir de la fecha de su petición, el empleador podrá transferir su cuidado a la MPN y estará obligado a utilizar un médico de la MPN.

Tendrá que darle una copia del informe a su empleador si desea posponer la transferencia de su cuidado. Si usted o su empleador no está de acuerdo con el informe de su médico sobre su condición, usted o su empleador puede disputarlo. Vea el plan de transferencia de cuidado para más detalles sobre el proceso de resolución de disputa.

Para una copia del plan entero sobre la transferencia de cuidado en Inglés o Español, pregúntele a su contacto de la MPN.

- **¿Qué tal si estoy bajo tratamiento con un médico de la MPN que decide dejar la MPN?**

Su empleador o compañía de seguros tiene un plan de *"Continuidad de Cuidado"* por escrito que determinará si es que podrá continuar temporalmente su tratamiento por su lesión de trabajo actual con su médico si su médico ya no está participando en la MPN.

Si su empleador decide que usted no califica para continuar su tratamiento con el médico que no es un proveedor dentro de la MPN, usted y el médico que lo está atendiendo deberán recibir una carta para notificarle sobre esta desisión.

Si usted cumple con ciertos requisitos, tal vez podrá calificar para continuar su tratamiento con este médico hasta por un año antes de que tenga que cambiar a un médico de la MPN. Estos requisitos están expuestos en el recuadro descrito arriba, ***"¿Puedo continuar siendo tratado por mi médico?"***

Usted puede no estar de acuerdo con la decisión de su empleador de negarle la Continuidad de Cuidado con el proveedor que ya no es parte de la MPN. Si quiere continuar su tratamiento con este médico, pidale al médico que lo está atendiendo por un informe que indique si tiene una de las cuatro condiciones descritas en la caja de arriba para ver si califica para seguir recibiendo tratamiento de su médico actual.

El médico que lo está atendiendo tiene viente (20) días a partir de la fecha de su petición para darle una copia del informe sobre su condición. Si el médico que lo está atendiendo no le da el informe dentro de los viente (20) días a partir de la fecha de su petición, se aplicará la decisión de su empleador de negarle la Continuidad de Cuidado con su médico que ya no participa en la MPN, y se le pedirá que elija a un médico de la MPN.

Tendrá que darle una copia del informe a su empleador o a su Gestor de reclamos si desea posponer la selección de otro médico de la MPN para su tratamiento continuo. Si usted o su empleador no está de acuerdo con el informe de su médico sobre su condición, usted o su empleador puede disputarlo. Vea el plan de Continuidad de Cuidado para más detalles sobre el proceso de resolución de disputa.

Para una copia del plan de la Continuidad de Cuidado entero en Inglés o Español, pregúntele a su Contacto de la MPN.

- **¿Qué tal si tengo preguntas o necesito ayuda?**

  - **El Contacto de la MPN:** Usted siempre puede ponerse en contacto con el Contacto de la MPN o el Gestor de reclamos si necesita ayuda o una explicación sobre su tratamiento médico para su lesión o enfermedad de trabajo a:

    P.O. Box 14475, Lexington, KY 40512
    Número de teléfono gratuito para el Gestor de reclamos: 866.401.9222
    Número de teléfono gratuito para el contacto de la MPN: 866.401.9222, x2304195
    Número de teléfono gratuito para la Unidad de la Red de Referencias para recibir una lista de los proveedores de la MPN y/o Farmacias de la MPN: 1.800.327.3636, selección 4
    E-Mail de la MPN: CAMPN.Claim@thehartford.com

Si usted tiene preguntas referentes a sus necesidades de:

1) prescripciones médicas,
2) de proveedores de servicio de fisioterapia, terapia ocupacional, endurecimiento por trabajo o servicios de quiropráctico

en relación su lesión o enfermedad debido al trabajo, por favor contacte a su Gestor de reclamos al 866.401.9222.

Si tiene alguna queja de la MPN, póngase en contacto con su Contacto de la MPN.

Si necesita ayuda para encontrar a un proveedor de la MPN disponible, o quiere asistencia para programar y confirmer citas con los proveedores, puede contactar a nuestros Asistentes de Acceso Médico sin cargo al 866-758-7256, de 7 a.m. a 8 p.m. Pacifico (lunes a sábado) (excepto domingos y feriados); por fax al 916-293-5025 o por correo electrónico a thehartfordmaa@primehealthservices.com. Al menos un Asistente de Acceso Médico está disponible para responder en todos los momentos solicitados, pudiendo las personas que llaman dejar un mensaje de voz. Los Asistentes de Acceso Médico responderán los llamados, faxes o mensajes antes del día siguiente, excepto domingos y feriados. Los Asistentes de Acceso Médico trabajan en conjunto con el Contacto MPN y el (los) Gestor(es) de reclamos para asegurarse de que usted, el trabajador lesionado, tenga tratamiento médico adecuado a tiempo. Asistencia prestada por los médicos asistentes de acceso está disponible en inglés y español.

- **La División de Compensación de Trabajadores (DWC):** Si tiene alguna preocupación, queja o pregunta sobre la MPN, el proceso de notificación, o su tratamiento médico después de una lesión o enfermedad de trabajo, puede llamar a la Oficina de Información y Asistencia de la DWC al 1.800.736.7401. También puede consultar con la página web de la DWC en el www.dir.ca.gov/dwc y hacer clic en "red de proveedores médicos" [medical provider networks] para más información sobre las MPN.

- **Revisión Médica Independiente:** Si usted tiene preguntas sobre el proceso de la Revisión Médica Independiente póngase en contacto con la Unidad Médica de la División de Compensación de Trabajadores en:

  DWC Medical Unit
  P.O. Box 71010
  Oakland, CA 94612
  510.286.3700 o 800.794.6900

Guarde esta información en caso que tenga una lesión o enfermedad de trabajo.

NOTICE
TO EMPLOYEES

State of Connecticut Workers' Compensation Commission **Revised 10-01-2017**

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer, TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason to the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name Twin City Fire Insurance Company **Telephone** (800)-327-3636

Address One Park Place, 300 South State Street, 8th Floor

City/Town Syracuse **State** NY **Zip Code** 13202

Approved Medical Care Plan ☐ **Yes** ☐ **No**

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address 999 Asylum Avenue

Telephone (860)-566-4154

City/Town Hartford **State** CT **Zip Code** 06105

Public Act 17-141 allows the employer the option to designate and post - "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] - a location where employees must file claims for compensation.

If your employer has listed a location below, you MUST file your compensation claim there.
When filing your claim, you are also required - by law - to send it by certified mail.
If blank below, ask your employer where to file your claim.

Employer Name Twin City Fire Insurance Company

Address

Telephone

City/Town **State** **Zip Code**

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLDFACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted:

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company or the Workers' Compensation Commission (1-800-223-9675).

WC 88 06 02 C Printed in U.S.A.

NOTICE

Drugs Don 't Work Here

State of Florida, Workers' Compensation Law, ss. 440.101, 440.102, F.S.

000102 264/304 3 01

We are committed to a drug-free workplace

Illegal use or possession of drugs or alcohol may lead to:

- **Loss of Employment, and/or**
- **Loss of Workers' Compensation Benefits**

For drug-testing information call:

Certified Medical Review Officer:
Name
Address
Telephone #

If you have questions about the denial of your Workers' Compensation Medical and/or Indemnity Benefits, please call the Workers' Compensation Employee Assistance Office at 1-800-342-1741.

STATE OF FLORIDA
DIVISION OF WORKERS' COMPENSATION, BUREAU OF RESEARCH AND EDUCATION

Form WC 88 09 11 Printed in U.S.A.

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

OFFICIAL NOTICE

This business operates under the Georgia Worker's Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

000102 265/304 3 01

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible.The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about worker's compensation.The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682
http://www.sbwc.georgia.gov

Concentra Urgent Care *
109 Minis Ave Ste C-10
GARDEN CITY GA 31408-2128
(912) 966-5445
CLINIC

Curtis V. Cooper Primary Healthcare Inc.
106 E Broad St
SAVANNAH GA 31401-2917
(912) 527-1000
PRIMARY CARE

Nova Medical Centers *
1128 E DeRenne Ave
SAVANNAH GA 31406-2015
(912) 231-7900
CLINIC

Sarzier, John S., MD
790 Veterans Pkwy Ste 111
HINESVILLE GA 31313-4354
(912) 342-7112
NEUROSURGEON

Shults, Jonathan M., MD *
8882 Abercorn St
SAVANNAH GA 31406-4508
(912) 777-6920
ORTHOPEDIC SURGEON

The Neurological Institute of Savannah & Center of Spine PC
4 E Jackson Blvd
SAVANNAH GA 31405-5710
(912) 355-1010
NEUROSURGEON

(Additional doctors may be added on a separate sheet)
The insurance company providing coverage for this business under the Workers' Compensation Law is:

Twin City Fire Insurance Company
Name

200 Colonial Center Pkwy, Ste, 500
Lake Mary FL 32746 (800) 327-3636
address phone

IF YOU HAVE ANY QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov.

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000 per violation (O.C.G.A. §34-9-18 and §34-9-19).

Insured Address: NO SPECIFIC LOCATION
SAVANNAH GA 31302

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

OFFICIAL NOTICE

This business operates under the Georgia Worker's Compensation Law.

Curtis V. Cooper Primary Healthcare Inc.
349 W Bryan St
SAVANNAH GA 31401-2356
(912) 527-2727
PRIMARY CARE

Georgia Eye Institute
4720 Waters Ave
SAVANNAH GA 31404-6292
(912) 354-4800
OPHTHALMOLOGIST

Balthrop, Paul M., MD *
4750 Waters Ave Ste 202
Savannah GA 31404
(912) 350-7412
ORTHOPEDIC SURGEON

Sofianos, Dmitri A., MD *
4425 Paulsen St Fl 2 Bldg 1
SAVANNAH GA 31405-3663
(912) 355-6615
ORTHOPEDIC SURGEON

000102 266/304 3 01

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $675 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $675 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $450 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $450 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $675 per week. A widowed spouse with no children will be paid a maximum of $270,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.
3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: http://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-237-2629.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov. WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 and §34-9-19).

TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE UPON YOUR PREMISES.

NOTICE

REGARDING WORKERS' COMPENSATION INSURANCE

000102 268/304 3 01

TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA
MARSH USA INC

ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPLIED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKERS' COMPENSATION LAW.

Twin City Fire Insurance Company
Northbelt II ? 785 Greens Pkwy, Ste 210
Houston TX 77067-4409

_____
Employer

_____
Date

By _____
Employer's Authorized Agent

An employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer; by the surety,

or upon application, by the Industrial Commission in Boise, Idaho.

WORKERS' COMPENSATION

is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. **GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.

2. **NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.

3. **LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

   If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

   It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

4. **KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

   Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free:	866/352-3033	Chicago:	312/814-6611	Peoria:	309/671-3019	Springfield:	217/785-7087
Web site:	www.iwcc.il.gov	Collinsville:	618/346-3450	Rockford:	815/987-7292	TDD (Deaf):	312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims	Twin City Fire Insurance Company		
Business address	4245 Meridian Parkway Aurora IL 60504		
Business phone	(800) 327-3636		
Effective date	07/31/2021	Termination date	07/31/2022
Policy number	10 WB AT1140	Employer's FEIN	23-1352685

ICPN 10/11 Printed by the authority of the State of Illinois.

Form WC 88 12 00 H Printed in U.S.A.

NOTICE

WORKERS' COMPENSATION ACCIDENT REPORTING

000102 270/304 3 01

You Have Workers' Compensation Insurance with The Hartford

WHEN AN EMPLOYEE IS INJURED ON THE JOB, OR DOES NOT REPORT FOR WORK:

1. **Inquire as to cause of absence, if unknown.**

2. **If employee is injured on the job, or, if absence may be due to injury or illness related to employment:**

   a. **Provide proper medical attention.**
   b. **Complete the Employers First Report of Injury (FROI) form in duplicate at once. This form can be obtained from the following website: www.iowaworkforce.org/wc/publications.htm.**
   c. **Mail original immediately to:**

      Twin City Fire Insurance Company
      4245 Meridian Parkway
      Aurora IL 60504

   d. **If employee is (or will be) away from work for more than three days, mail copy to:**

      Iowa Industrial Commissioner
      1000 E. Grand Avenue
      Des Moines, IA 50319-0209

KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 7-19)

*THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER APRIL 25, 2013 *

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) NOTIFY YOUR EMPLOYER IMMEDIATELY: Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) 20 calendar days from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, 20 calendar days from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, 10 calendar days after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3 percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

DIVISION OF WORKERS COMPENSATION - OMBUDSMAN / CLAIMS ADVISORY UNIT
401 SW Topeka Blvd., Ste. 2, Topeka, KS 66603-3105. Phone (785) 296-4000, (800) 332-0353. Fax (785) 296-0025

RESPONSIBILITIES OF THE EMPLOYER

1. Unless self-insured, the employer must advise its insurance carrier or group-funded pool of employee's injury.

   Per K.S.A. 44-557, it is the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

   As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3.1 Standards. For details contact the Technology and Statistics section of the Division of Workers Compensation at (785) 296-4000 or (800) 332-0353. You may access our website at http://www.dol.ks.gov/wc/insurer/electronic-data-interchange-(edi).
2. Employers must provide for the payment of workers compensation claims without any charge to employees.
3. Employers must post the Workers Compensation Notice prepared by the Director.
4. Employers must pay compensation benefits, regardless of insurance coverage.
5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

Pursuant to K.S.A. 44-5, 102 (a)
EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company Twin City Fire Insurance Company

Address 4245 Meridian Parkway

Aurora, IL 60504

Contact Person _____

Phone (800) 327-3636 **Fax:** _____

Email _____

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 7-19)

ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE ABRIL 25, 2013

Empleadores son requeridos de proveer ésta información a cada trabajador que se lesiona

¿QUÉ HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

Si tiene preguntas acerca de beneficios de compensación del trabajador, contacte la unidad mencionada al final de página. **Asistencia en Español está disponible.**

(1) NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE: De acuerdo con el artículo de la ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador antes de las siguientes fechas: (A) 20 días a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, 20 días a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, 10 días después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

(2) SIGA LAS INSTRUCCIONES DE SU EMPLEADOR para conseguir ayuda médica y siga las instrucciones del doctor.

(3) BENEFICIOS MÉDICOS: El trabajador lastimado tiene derecho a todo servicio médico razonablemente necesario para curar y aliviar al trabajador de los efectos de la lesión. El empleador tiene el derecho de seleccionar el doctor quien dará el tratamiento necesario. El trabajador tiene derecho de escoger los servicios de otro doctor no autorizado hasta llegar al límite de 500.00 dólares. El trabajador puede solicitar al Director de Compensación de Trabajadores el cambio del doctor autorizado. Los gastos incurridos en viajes hechos para obtener tratamiento médico serán reembolsados según sean estipulados por ley por viajes que incluyen más de cinco millas, viaje redondo.

(4) BENEFICIOS SEMANALES: Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los trabajadores lesionados no tienen derecho a compensación por la primera semana, a menos que estén sin trabajar tres semanas consecutivas.

DIVISION OF WORKERS COMPENSATION – OMBUDSMAN / CLAIMS ADVISORY UNIT
401 SW Topeka Blvd., Ste. 2, Topeka, KS 66603-3105 . Phone (785) 296-4000, (800) 332-0353 . Fax (785) 296-0025

El primer pago de compensación normalmente se vence al fin de los 14 días de estar sin trabajar. Un trabajador lesionado tiene derecho a una cantidad semanal de 66 2/3 por ciento de su sueldo promedio semanal hasta un máximo de 75 por ciento del sueldo promedio semanal del estado. Estos beneficios están sujetos a cambios por la legislatura. Si la lesión resulta en incapacidad permanente, la ley del Estado de Kansas para Compensación de Trabajadores provee beneficios adicionales.

RESPONSABILIDADES DEL EMPLEADOR

1. A menos que esté auto-asegurado, el empleador debe informar a su compañía de seguros o grupo financiero mancomunado de la lesión el empleado.

   Por K.S.A. 44-557, es deber de cada empleador hacer o causar que se haga un informe al director de cualquier accidente, reclamo o supuesto accidente a cualquier empleado que le ocurra en el curso de su empleo, y del cual el empleador o su supervisor tienen conocimiento, dicho informe deberá ser hecho en un formulario preparado por el director, dentro de los próximos 28 días después de la recepción de dicho conocimiento, si las lesiones sufridas por tales accidentes, son suficientes para incapacitar parcial o totalmente a la persona lesionada ya sea en trabajo de mano de obra o prestando algún servicio por más que el resto del día o turno en el que tales lesiones fueron sufridas.

   Como se describe en K.A.R. 51-9-17, todas las compañías de seguros, grupos mancomunados y auto-asegurados, están obligados a utilizar el Intercambio Electrónico de Datos (EDI, por sus siglas en Ingles) para presentar le Primer Reporte de Accidente (FROI, por sus siglas en Ingles) y Subsecuentes Reportes de Lesiones (SROI, por sus siglas en Ingles) utilizando el Lanzamiento de Nivel 3.1. Puede acceder a nuestro sitio web en http://www.dol.ks.gov/wc/insurer/electronic-data-interchange-(edi)
2. Los empleadores deben suministrar el pago de los reclamos sin costo a los empleados.
3. Los empleadores deben exhibir un Aviso de Compensación al trabajador, preparado por el Director.
4. Los empleadores deben pagar beneficios de compensación sin importar la cobertura de seguro.
5. Tan pronto como se reciba el aviso de una lesión, el empleador debe proveer información por escrito para ayudar al trabajador lesionado a entender sus derechos y responsabilidades al obtener compensación.

Conforme a la Ley K.S.A. 44-5, 102(a)
EMPLEADORES DEBEN COMPLETAR LA SIGUIENTE INFORMACIÓN PARA LOS TRABAJADORES LESIONADOS

SU RECLAMO SERÁ MANEJADO POR:

Compañía Twin City Fire Insurance Company

Dirección 4245 Meridian Parkway

Aurora, IL 60504

Persona de Contacto _____

Teléfono (800) 3273636 **Fax** _____

Correo electrónico _____

DIVISION OF WORKERS COMPENSATION – OMBUDSMAN / CLAIMS ADVISORY UNIT
401 SW Topeka Blvd., Ste. 2, Topeka, KS 66603-3105 . Phone (785) 296-4000, (800) 332-0353 . Fax (785) 296-0025

This notice must be posted and maintained by the employer in one or more conspicuous places.

Workers Compensation Rights and Responsibilities

Your employer is subject to the Kansas Workers Compensation Law which provides compensation for job-related injuries.

This notice applies to dates of accidents on or after April 25, 2013.

Este aviso aplica a las fechas de los accidentes a partir de Abril 25, 2013.

000102 275/304 3 01

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

NOTIFY YOUR EMPLOYER IMMEDIATELY.
Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) **20 calendar days** from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, **20 calendar days** from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, **10 calendar days** after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

BENEFITS. Benefits are paid by the employer's insurance carrier or self insurance program. Benefits include medical treatment, partial wage replacement for lost time and additional benefits if the injury results in permanent disability. An employer is required to furnish all necessary medical treatment and has the right to designate the treating physician. If the employee seeks treatment from a doctor not authorized by the employer, the employer or its insurance carrier is only liable up to $500.00 dollars for the unauthorized medical treatment.

QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE.
De acuerdo con el artículo de ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de antes de las siguientes fechas: (A) **20 días** a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, **20 días** a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, **10 días** después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

BENEFICIOS. Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los beneficios incluyen tratamiento médico, reemplazo de sueldo parcial por tiempo perdido y beneficios adicionales si la lesión resulta en incapacidad permanente. El empleador debe proporcionar todo el tratamiento médico necesario y tiene el derecho de designar el doctor para dicho tratamiento. Si el empleado busca tratamiento con un doctor que no ha sido autorizado por el empleador, el empleador o su compañía aseguradora serán responsables de pagar solamente los primeros $500.00 dólares para tratamiento médico no autorizado.

WHERE TO GET HELP WITH YOUR CLAIM (DÓNDE CONSEGUIR AYUDA CON SU RECLAMO):

Twin City Fire Insurance Company — (800) 327-3636

Employer's Insurance Carrier (Compañía Aseguradora del Empleador) — Telephone (Teléfono de la Aseguradora)

4245 Meridian Parkway, Aurora, IL 60504

Address (Dirección de la Aseguradora)

For questions about Workers Compensation Law, contact (Para preguntas acerca de la Ley de Compensación del Trabajador):

KANSAS DEPARTMENT OF LABOR
Division of Workers Compensation/Ombudsman
401 SW Topeka Blvd., Suite 2, Topeka, KS 66603-3105

Website: www.dol.ks.gov/workcomp/default.aspx
Email: KDOL.wc@ks.gov
Phone: (800) 332-0353 or (785) 296-4000

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at (800) 766-3777.

COMMONWEALTH OF KENTUCKY
WORKERS COMPENSATION NOTICE

000102 276/304 3 01

Employees of this business are covered by the Kentucky Workers Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA
Address: 2929 WALNUT ST STE 460
PHILADELPHIA PA 19104-5099
Workers Compensation Carrier
(or third party administrator): Twin City Fire Insurance Company
Policy #: 10 WB AT1140 , **effective** 07/31/21 **to** 07/31/22
Address: 4245 Meridian Parkway
Aurora IL 60504
Telephone: (800) 327-3636 , **Contact Person** _____

EMPLOYEES: If INJURED-NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical Care. The name of the Managed Care Plan is _____;
its representative is _____ , phone number _____.

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers' Compensation Act after seven (7) days of disability. A CLAIM MUST BE filed with the Department of Workers' Claims WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers compensation rights are not promptly answered call The KENTUCKY DEPARTMENT OF WORKERS' CLAIMS at 1-800-554-8601 to speak to an Ombudsman or Workers Compensation Specialist.

EMPLOYER SUPERVISORS-NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

01/10/97 (rev 10/09)
Form WC 88 16 02 C Printed in U.S.A.

Workers' Compensation

Reporting Injury
You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death
In case of an occupational disease, all claims are barred unless the employee files a claim with his employer within one year of the date that:

1. the disease manifests itself.
2. the employee is disabled as a result of the disease.
3. the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) files a claim with the deceased employee's employer within one year of:

1. the date of death.
2. the date the claimant has reasonable grounds to believe that the death resulted from an occupational disease.

Filing Notice
In case of injury or death caused by a work related accident, an injured employee or any person claiming to be entitled to compensation, either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil penalties.

The aforementioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians
In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim
In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made, or within one year after the last payment of weekly benefits.

Information
If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised May 2003

Employer
TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

Name and Address of Insurance Company
Twin City Fire Insurance Company
785 Greens Parkway, Suite 210
Houston TX
77067

LOUISIANA
WORKFORCE
COMMISSION
www.laworks.net

000102 277/304 3 01

NOTICE TO EMPLOYEES

NOTICE TO EMPLOYEES

000102 278/304 3 01

The Commonwealth of Massachusetts
DEPARTMENT OF INDUSTRIAL ACCIDENTS

LAFAYETTE CITY CENTER, 2 AVENUE DE LAFAYETTE, BOSTON, MA 02111
(617) 727-4900 – http://www.ma.gov/dia

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

Twin City Fire Insurance Company
NAME OF INSURANCE COMPANY

One Park Place, 300 South State St, 7th Floor Syracuse NY 13202
ADDRESS OF INSURANCE COMPANY

10 WB AT1140		07/31/21 - 07/31/22
POLICY NUMBER		**EFFECTIVE DATES**
MARSH USA INC	1166 AVE OF AMERICAS 41ST FLR NEW YORK NY 10036	(212)-345-6000
NAME OF INSURANCE AGENT	**ADDRESS**	**PHONE**
TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA	2929 WALNUT ST STE 460 PHILADELPHIA PA 19104-5099	
EMPLOYER	**ADDRESS**	

EMPLOYER'S WORKERS COMPENSATION OFFICER (IF ANY) **DATE**

MEDICAL TREATMENT

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

NAME OF HOSPITAL **ADDRESS**

TO BE POSTED BY EMPLOYER

Form WC 88 20 01 E Printed in U.S.A.

Minnesota Workers' Compensation
Employee's rights and responsibilities

000102 279/304 3 01

This notice is required by law to be posted in a conspicuous location wherever the employer is engaged in business.

If You Are Injured:

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not timely report the injury to your employer. The time limit may be as short as 14 days, although under certain circumstances, it may be longer.
- Provide your employer with as much information as possible about your injury so that a proper injury report can be filed.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you if you are covered by a CMCO.
- Cooperate with all requests for information concerning your workers' compensation claim. Please note: the law provides that the workers' compensation insurer can obtain medical information specific to your work injury without your authorization, provided you are sent written notification of this request at the time the request is made.
- Get written confirmation from your doctor on any authorization to be off work.

What does workers' compensation pay for?

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

What the insurance company must do:

- Investigate your claim promptly;
- Within 14 days of when the claimed injury occurred or when your employer became aware of it, either begin payment of benefits due or file a denial of liability, explaining why benefits are being denied.

Insurer name:	**Phone number:**
Twin City Fire Insurance Company	(800) 327-3636

If the insurer accepts your claim for wage-loss benefits and you have been disabled for more than three calendar-days:

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer denies your claim for wage-loss benefits:

- The insurer will send you a copy of the Notice of Insurer's Primary Liability Determination form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work. .
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.
- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to discuss your options.

Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Any theft of more than $500 is a felony.

Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3.

A suspected fraud can be reported by anyone. If you have reason to suspect someone is committing workers' compensation fraud, call 1-888-FRAUD MN (1-888-372-8366). All suspected violations will be investigated.

If you have questions or need more help, call the Minnesota Department of Labor and Industry:

Workers' Compensation Hotline
1-800-DIAL-DLI
(1-800-342-5354)
8 a.m. to 4:30 p.m.,
Monday-Friday

Department of Labor and Industry
Workers' Compensation Division
P O Box 64221
St. Paul, MN 55164-0221
Phone: (651) 284-5032
TDD: (651) 297-4198

Department of Labor and Industry
Workers' Compensation Division
5 .N. Third Ave. W., Suite 400
Duluth, MN 55802
Phone: (218) 733-7810
Toll-free: 1-800-365-4584

Your claim will be answered by experienced workers' compensation specialists who will provide **instant, accurate information and assistance.** Additional workers' compensation information is available on the department Web site at www.doli.state.mn.us.

This document can be made available in alternative formats, such as Braille or audio, by calling (651) 284-5042 or (651) 297-4198/TDD.

September 2008
Form WC 88 22 01 F Printed in U.S.A.

MISSISSIPPI WORKERS' COMPENSATION

NOTICE OF COVERAGE

000102 280/304 3 01

I. Please take notice that your Employer is in compliance with the requirements of the Mississippi Workers' Compensation Law, and maintains workers' compensation insurance coverage with the following:

Twin City Fire Insurance Company
(Name of insurance carrier or self-insurance group)
3600 WISEMAN BLVD
SAN ANTONIO TX 78251
(877) 853-2582
(address & telephone number)

II. Individual workers' compensation claims will be submitted to and processed by:

Twin City Fire Insurance Company
(Name of third party claims administrator or claims office)
200 Colonial Center Pkwy, Ste, 500
Lake Mary FL 32746
(800) 327-3636
(address & telephone number)

III. This workers' compensation coverage is effective for the following period:

07/31/21 to 07/31/22.

IV. All job related injuries or illnesses should be reported as soon as possible to your immediate supervisor, or to the person listed below:

(Name of employer contact person)

(Title & Department/Division)

V. Please be advised that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under the Mississippi Workers' Compensation Law may be charged with violation of Miss. Code Ann. §71-3-69 (Rev. 2000) and upon conviction be subjected tot he penalties therein provided.

Mississippi Workers' Compensation Commission
1428 Lakeland Drive / Post Office Box 5300
Jackson, Mississippi 39296-5300
(601)987-4200
http://www.mwcc.state.ms.us

2012

MISSISSIPPI

WORKERS' COMPENSATION FACTS

WHAT IS WORKERS' COMPENSATION?

Workers' compensation is essentially a no-fault insurance plan mandated by State law, supervised by the Workers' Compensation Commission and paid for entirely by employers. The Workers' Compensation Law was enacted by the Legislature in 1948 to guarantee the payment of certain medical and wage loss benefits to persons injured on their job. As part of this Law, the Workers' Compensation Commission, with its office in Jackson, MS, was established to supervise and monitor claims which arise under the Law. An employer covered by the Law is required to secure the payment of workers' compensation benefits to its employees by purchasing workers' compensation insurance from an insurance company or by obtaining approval from the Commission to self-insure.

WHO IS COVERED?

Most working Mississippians are protected by the Workers' Compensation Law, but there are exceptions. All employers with five (5) employees regularly employed are required to provide workers' compensation insurance coverage. If the employer has less than five (5) employees, workers' compensation coverage is not mandatory but may be provided voluntarily by the employer. Domestic and farm labor, and employees of non-profit fraternal, charitable, religious or cultural organizations are not covered under the Law unless coverage is provided voluntarily by the employer. The Workers' Compensation Law likewise does not apply to federal employees or certain transportation and maritime employments covered by federal compensation laws. Finally, independent contractors are ordinarily excluded from coverage although special protection is given to employees of subcontractors.

WHAT IS COVERED?

Any injury, however slight or serious, is covered if it arises out of the course and scope of employment. Occupational illnesses and diseases are also covered if job-related, as are work related deaths.

WHEN DOES COVERAGE BEGIN?
The worker is covered and eligible for benefits as soon as he or she begins employment. There is no waiting period or minimum earnings requirement.

WHAT MUST AN INJURED WORKER DO IN THE EVENT OF INJURY?
In the event of an injury, you should immediately notify your supervisor or other person designated by your employer. Prompt and accurate reporting is essential. Your employer is then required to make a report of the injury and notify its insurance company and/or the Workers' Compensation Commission. An injured employee should try to give the employer notice of the injury within 30 days. If no disability benefits are paid to the injured worker by the employer or carrier within two (2) years of the date of injury, then the right to any and all benefits is barred unless the employee files a claim with the Commission during this two (2) year period. This is what is known as the two (2) year statute of limitations.

PLEASE BE ADVISED:

"Any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under (the Workers' Compensation Law) is guilty of a felony and on conviction thereof may be punished by a fine not to exceed Five Thousand Dollars ($5,000.00) or double the value of the fraud, whichever is greater, or by imprisonment not to exceed three (3) years, or by both fine and imprisonment."

WHAT BENEFITS ARE AVAILABLE?

The Workers' Compensation Law provides two basic benefits to the injured worker:

Medical Benefits. An injured worker is entitled to whatever reasonable and necessary medical services are required to treat the injury and achieve maximum cure. These include but are not limited to doctor and hospital services, nursing services, medication, physical therapy, crutches and any other apparatus or medical service which is necessary. Mileage expense reimbursement for trips to the doctor is also included; consult the Commission's internet site at www.mwcc.state.ms.us for current rates. Certain rehabilitation services may also be provided to assist the worker in his recovery and return to gainful employment.

Wage Loss Benefits. If an injured worker is required because of the injury to miss time from work, then he or she is entitled to a wage loss benefit equal to as much as two-thirds of the workers' average weekly wage, subject to a maximum weekly amount and to certain time limits which are set by the Legislature. While the worker is under the continuing care of a doctor and is unable to work or to earn full pay, this benefit is known as a "temporary disability" payment. Once the doctor finds the worker has achieved maximum cure or improvement, additional wage loss benefits known as "permanent disability" payments may be due if the worker has a permanent disability or handicap. All wage loss benefits are required to be paid at least every 14 days so long as the covered disability continues, subject to certain statutorily provided time limits.

WHAT IF DEATH OCCURS?

If the injury causes death, the Workers' Compensation Law guarantees the payment of benefits to any surviving spouse and certain surviving dependents. These benefits are payable at least every 14 days, and may continue for up to 450 weeks after the decedent's death. These benefits equal a certain percentage of the deceased worker's average weekly wage, and are subject to a weekly maximum amount set by statute. Also, the employer or its insurance carrier is obligated to pay up to $2,000.00 in funeral expenses, as well as an immediate lump sum payment of $250.00 to the surviving spouse.

MORE ABOUT MEDICAL BENEFITS.

The Workers' Compensation Law provides that an injured worker has the right to select one physician or medical provider of his or her own choosing to render treatment. This chosen provider may make one referral of the worker to a another specialist to continue treatment without any approval from the employer or its insurance carrier. However, any additional selections or referrals must be approved in advance by the employer or its insurance carrier. The worker is not limited to a licensed medical doctor and may choose, for example, a chiropractor for treatment. The worker is also entitled to mileage reimbursement for trips to the doctor.

IS THERE A DEDUCTIBLE?

There is no deductible to be paid by the worker for any of the benefits received. An employer may have a deductible arrangement with its insurance company, but all workers' compensation benefits are provided at no cost to the employee.

PLEASE BE ADVISED:

"Any employee receiving (medical) treatment or service under the (Workers' Compensation Law) may not be held responsible for any charge for such treatment or service, and no doctor, hospital or other recognized medical provider shall attempt to bill, charge or otherwise collect from the employee any amount greater than or in excess of the amount paid by the employer, if self-insured, or its workers' compensation carrier."

"No agreement by an employee to pay any portion of premium paid by his employer or to contribute to a benefit fund or department maintained by such employer for the purpose of providing compensation or medical services and supplies as required by (the Workers' Compensation Law) shall be valid. Any employer who makes a deduction for such purpose from the pay of any employee entitled to (workers' compensation) benefits . . . shall be guilty of a misdemeanor. . ."

HOW ARE PAYMENTS MADE?

All payments are made by the employer or its insurance company, *not* by the Workers' Compensation Commission.

Medical payments should be made directly to the doctor or other medical provider by the employer or its insurance company. Wage loss payments should be made directly to the injured worker or the workers' legal representative. Once started, wage loss or disability payments to the worker should be made at least every 14 days until concluded.

ARE BENEFITS PAID FOR ALL DAYS MISSED FROM WORK?

Medical benefits are paid regardless of the number of days missed from work. If the injured worker suffers fewer than 14 days of disability (days on which the worker is unable due to injury to earn his regular wage) as the result of a job related injury, wage loss payments are not made for the first 5 days. Payment will be made only for the number of days of disability in excess of 5. This is known as the 5 day waiting period. If the worker suffers 14 or more days of disability, then wage loss payments are made for the total period of disability, including the first 5 days.

HOW MUCH ARE WAGE LOSS PAYMENTS?

Depending on the nature of the injury and disability, payments will be as much as two-thirds of the workers' average weekly wage, subject to a maximum weekly amount set by the Legislature. No worker is entitled to receive more than 450 times the maximum weekly amount established by the Legislature, regardless of the type of injury. In death cases, this limit applies to the total of payments to spouse and dependents.

Effective for injuries or fatalities occurring on or after January 1, 2012, the maximum weekly benefit for disability or death is $436.68. The maximum overall limit is 450 times this amount, or $196,506.00. These figures represent the maximum amount which can be paid for an injury or death. Depending on one's average weekly wage, benefits may be less, since you are entitled to the lesser of 2/3 of your average weekly wage or the weekly maximum in effect at the time of your injury. Please consult the minimum/maximum benefits chart available at *www.mwcc.state.ms.us* for the maximum benefit rate for years other than 2012.

HOW LONG WILL WAGE LOSS PAYMENTS CONTINUE?

For a worker permanently and totally disabled, payments will be made for a maximum period of 450 weeks. For injuries which result in less than permanent and total disability, the time limit for payments varies according to the nature of the injury and disability. In cases of death, payments to dependents may not exceed 450 weeks.

WHAT IF THERE IS A PROBLEM?

If you encounter a problem with the way your claim is being handled, or you think you have not received all benefits due, first contact the employer or insurance company representative handling your claim. Many problems can be cleared up with a phone call. Remember, if your claim is accepted and paid, it will be paid by the employer or its insurance carrier and not by the Workers' Compensation Commission. If the problem cannot be resolved in this manner, you may contact the Mississippi Workers' Compensation Commission at 601-987-4200 and ask to speak with a Claims Representative. A Claims Representative may be able to help you resolve your problem.

DOES THE INJURED WORKER NEED AN ATTORNEY?

Fortunately, the majority of claims are handled routinely and without any dispute. However, there are instances when you may not be able to resolve disputes yourself or through a Claims Representative of the Commission. In such cases, the assistance of an attorney can be invaluable. You are not required to hire an attorney, but you may consult with and hire an attorney of your own choosing at anytime. Most attorneys are paid by retaining a percentage of the compensation you receive after the attorney is hired. So long as your claim is pending before the Commission, an attorney may not retain more than 25% of the total compensation paid to you. If your claim is appealed to a court of law, up to 33 1/3% of the total compensation may be set aside for attorney's fees.

SAFETY IS IMPORTANT!

While the Workers' Compensation Law exists to guarantee certain benefits for persons who sustain bona fide work related injuries or illnesses, these benefits are limited and often will not make the injured person whole again. Prevention is the most valuable benefit and every worker should strive to prevent an injury from occurring. By adhering to safe work practices, many injuries can be prevented.

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Insurance Company, Third Party Administrator, Service Company, or Designated Individual If Self-Insured

Employee Information

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Name Twin City Fire Insurance Company

Address 4245 Meridian Parkway
Aurora
IL 60504

Phone (800) 327-3636

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the accident/or 30 days after the diagnosis of any occupational disease or repetitive trauma) by contacting

_____ , _____
employer representative phone number

Failure to do so may jeopardize your ability to receive benefits

2. **Ask your employer to provide medical treatment (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurers approval).**
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need. **Visit www.labor.mo.gov/DWC or call 800-775-COMP.**

Benefits for Injured Employees

Medical Care:
The employer or insurer is required to provide medical treatment and care that is reasonably required to cure and relieve the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately.** The employer/insurer has the right to choose the healthcare provider or treating physician. You may select a different healthcare provider or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages

- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:
If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:
If a work-related injury causes an employee's death, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

Additional Benefits for Occupational Diseases Due to Toxic Exposure - Permanent Total Disability and/or Death: For Information relating to additional benefits available, please refer to the Division's website at www.labor.mo.gov/DWC/ Injured Workers/benefits available.

**Make sure your data is turned on and scan the QR Code with your smartphone's camera to go to the Division of Workers Compensation's Website for more information. If you are not redirected, you may need to update your smartphone's operating system or download a QR Code Reader app.

Form WC 88 24 02 L Printed in U.S.A.

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

With some exceptions, all employers with five or more employees, and construction industry employers with one or more employees, are required to insure their workers' compensation liability, either by purchasing a policy or obtaining self-insurance authority. Workers' compensation insurance provides benefits to workers injured on the job. Employers also are required to post this notice in the workplace for employees to view. This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 800-775-Comp.

Steps to Take When an Injury Occurs

1. Be sure first aid is administered and the employee is taken to a physician or hospital for further medical care, if necessary.
2. Report the injury to the insurance company or Third Party Administrator (TPA) within five days of the date of injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. The insurer, TPA, or Division approved self-insurer is responsible for filing a First Report of Injury with the Division of Workers' Compensation **within 30 days** of knowledge of the injury.
3. Pay medical bills related to the work injury for treatment reasonably required to cure and relieve the employee of the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. The employer has the right to choose the healthcare provider or treating physician. (The employee may select a different healthcare provider or treating physician, but if the employee does so, it may be at his/her own expense.)
4. For more liability and insurance information relating to the Workers' Compensation Program, visit www.labor.mo.gov/ DWC or call 800-775-COMP.

Workers' Safety

Developing and implementing a comprehensive safety and health program can reduce occupational injuries and help lower workers' compensation costs. Insurance carriers in the state of Missouri must provide safety assistance at the request of the insured employer. The Missouri Department of Labor evaluates these services and provides additional assistance through its Missouri Workers' Safety Program.

Visit www.labor.mo.gov/MWSP or call 573-751-4231 for more information about these programs or for a registry of independent consultants who are certified in the state of Missouri to provide safety assistance.

Fraud/Noncompliance

Employee Fraud — knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence with intent to defraud is a class E felony, punishable by a fine of up to $10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Fraud — knowingly misrepresenting an employee's job classification or any other fact to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class E felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material representation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine of up to $10,000. A subsequent violation is a class D felony.

Insurer Fraud — knowingly and intentionally refusing to comply with workers' compensation obligations to which an insurance company or self-insurer knows an employee is entitled is a class E felony, punishable by a fine of up to $10,000 or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Noncompliance — knowingly failing to insure workers' compensation liability under the law is a class A misdemeanor punishable by a fine of up to three times the annual premium the employer would have paid had it been insured or up to $50,000, whichever is greater. A subsequent violation is a class E felony. An employer who willfully fails to post the notice of workers' compensation at the workplace is guilty of a class A misdemeanor punishable by a fine of $50 to $1,000 or by imprisonment or both fine and imprisonment.

Form WC 88 24 02 L Printed In U.S.A.

WC-106 (07-19) AI

NOTICE

WORKERS' COMPENSATION ACCIDENT REPORTING

You Have Workers' Compensation Insurance with THE HARTFORD

WHEN AN EMPLOYEE IS INJURED ON THE JOB, OR DOES NOT REPORT FOR WORK:

1. **Inquire as to cause of absence, if unknown.**

2. **If employee is injured on the job, or, if absence may be due to injury or illness related to employment:**

   A. **Provide proper medical attention.**

   B. **Complete the First Report of Alleged Occupational Injury or Illness form in duplicate at once. This form can be obtained from the following website: http://www.wcc.ne.gov/publications/form1.pdf.**

   C. **Mail original immediately to:**

Twin City Fire Insurance Company
4245 Meridian Parkway
Aurora IL 60504

The insurer must file a report of accident or settlement, electronically, with the workers' compensation court:

1) **within 48 hours of a death or hospitalization of 5 or more employees in one accident; and**

2) **within 10 days of notice of all other injuries resulting in:**
   a) **lost time;**
   b) **job transfer or termination;**
   c) **medical treatment;**
   d) **loss of consciousness;**
   e) **occupational disease; or**
   f) **restriction in work or motion.**

NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:
   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

Form WC 88 27 01 Printed in U.S.A.

NOTICE

000102 289/304 3 01

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes, New Jersey, by insuring with the

Twin City Fire Insurance Company

For the period

Beginning 07/31/21 **Ending** 07/31/22

Employer TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

Form 16 NJ A
Form WC 88 29 00 C Printed in U.S.A.

AVISO

000102 280/304 3 01

El patrón avisa que ha asegurado el pago de compensación a los empleados y sus dependientes, de acuerdo con lo provisto por la ley de responsabilidad de los patrones de seguro para sus empleados. Titulo 34, Capitulo 15, Articulo 5, revisión de estatutos del Estado de New Jersey, asegurándolos con.

Twin City Fire Insurance Company **Compañia de Seguro**

por el periodo

Comenzando 07/31/21

Terminando 07/31/22

Patrón TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

De acuerdo con la ley mencionada arriba, esta notica debe ser colocada y mantenida en un lugar visible en todos los lugares de trabajo.

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACIÓN OBRERA

NOTICE OF COMPLIANCE
TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain first aid or other necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
P O Box 5205
Binghamton, NY 13902-5202

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO
A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad, relacionada con el trabajo usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es refendo por un médico autonzado) que este autonzado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cuelquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratmiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su case o la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene usted dificultad en conseguir un formulario de reclamación o necesita ayuda para llenalo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniguese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE

Workers' Compensation Board

000102 291/304 3 01

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self insurer

Twin City Fire Insurance Company

One Park Place, 300 South State Street, 8th Floor
Syracuse, NY 13202
(800)-327-3636

For Insurance Carriers ONLY: Policy No. 10 WB AT1140
Policy in Force from: 07/31/21 to 07/31/22

Name of employer (Nombre del patrono)
TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17) Workers' Compensation Board
Prescribed of by Chairman
State of New York

www.wcb.ny.gov

Form WC 88 31 14 S Printed in U.S.A.

CC-Form-1A *Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees*

All employees of this employer who are entitled to benefits of the Administrative Workers' Compensation Act are hereby notified that this employer has complied with all rules of the Workers' Compensation Commission and that this employer has secured payment of compensation for all employees and their dependents in accordance with the Act. All employees are further notified this employer will furnish first aid, medical, surgical, hospital, optometric, podiatric, and nursing services, medicine, crutches and other apparatus as may be reasonably necessary in connection with the injury received by the employee, as well as payments of compensation to any injured employee or the employee's dependents as provided in the Act.

Any employee who has suffered a compensable injury covered by the Administrative Workers' Compensation Act is entitled to vocational rehabilitation services, including retraining and job placement, if, as a result of the injury, the employee is unable to perform work for which the person has previous training or experience.

000102 292/304 3 01

The Oklahoma Workers' Compensation Commission has a Counselor Division to provide information to injured workers, employers, and other interested persons.

Mediation is available to help resolve certain workers' compensation disputes. For information, call the Counselor Division at 405-522-5308 or In-State Toll Free 855-291-3612.

Signature of Employer

Twin City Fire Insurance Company

4245 Meridian Parkway, Suite 101 Aurora IL 60504

Insurer Name and Address

07/31/22

Employee's Responsibilities In Case of Work Related Injury

If accidentally injured or affected by cumulative trauma or an occupational disease arising out of and in the course of employment, however slight, the employee should notify the employer immediately. If this employer is a partnership, notice shall be given to any partner. If this employer is a corporation, notice shall be given to any agent or officer of the corporation upon whom legal process may be served. Notice shall also be given to the person in charge of business at the location of operations where the injury occurred. Unless oral or written notice is given to the employer within thirty (30) days, the claim for compensation may be forever barred.

The employee may file a claim for compensation with the **WORKERS' COMPENSATION COMMISSION** for an accidental injury, death, cumulative trauma or occupational disease or illness occurring **ON OR AFTER** February 1, 2014. Forms to file a compensation claim should be furnished by this employer and also are available from the Workers' Compensation Commission. The forms are posted on the Commission's website, www.wcc.ok.gov.

A claim for compensation must be filed with the Commission within the time specified by law, or be forever barred. Based on law effective May 28,2019, a claim for compensation for any accidental injury must be filed with the Commission within one (1) year of the date of injury or, if the employee has received benefits under Title 85A for the injury, six (6) months from the date of the last issuance of such benefits; a death claim must be filed within two (2) years of the date of death; a claim for compensation for occupational disease or illness must be filed within two (2) years of the last injurious exposure; and a claim for compensation for cumulative trauma must be filed within one (1) year of the date of injury.

Claims for compensation for accidental injury, death, cumulative trauma or occupational disease or illness occurring BEFORE February 1, 2014 may be filed with the WORKERS' COMPENSATION COURT OF EXISTING CLAIMS and are subject to different notice of injury requirements and claims filing deadlines than those for accidental injury, death, cumulative trauma or occupational disease or illness occurring on or after February 1, 2014. Failure to comply with applicable notice requirements and deadlines may operate to forever bar the claim. Contact the WORKERS' COMPENSATION COURT OF EXISTING CLAIMS for additional information.

Employers' Responsibilities

The employer must provide employees with immediate first aid, medical, surgical, hospital optometric, podiatric, and nursing services, medicine, crutches and other apparatus as may be reasonably necessary in connection with the injury received by the employee. This applies to care for all injuries and illnesses arising out of and in the course of employment, regardless of their character. Within ten (10) days after the date of receipt of notice or knowledge of death or injury that results in the loss of time beyond the shift or medical attention away from the work site, the employer or the employer's representative MUST send a report thereof to the Workers' Compensation Commission via Electronic Data Interchange as specified in Commission rules.

No agreement by any employee to pay any portion of the premium paid by the employer to a carrier or a benefit fund or department maintained by the employer for the purpose of providing compensation or medical services and supplies as required by the workers' compensation laws, shall be valid. Any employer who makes a deduction for such purposes from the pay of any employee entitled to benefits under the workers' compensation laws shall be guilty of a misdemeanor.

No agreement by any employee to waive workers' compensation rights and benefits shall be valid.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Workers' Compensation Commission
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
Tele. 405-522-5308 (OKC) o 918-295-3732 (TU) o In-State Toll Free 855-291-3612
Web Site o www.wcc.ok.gov

This notice must be posted and maintained by the employer in one or more conspicuous places on the work prei

STATE OF RHODE ISLAND
DEPARTMENT OF LABOR & TRAINING

000102 293/304 3 01

This employer is subject to the provisions of the

WORKERS' COMPENSATION ACT

of the State of Rhode Island

Workers' Compensation Insurance Company: Twin City Fire Insurance Company

Adjusting Company: _____

Telephone: _____ Policy Effective Date: 07/31/21

In accordance with Rhode Island General Law §28-32-1, the **employer must report to the Director of Labor and Training every personal injury sustained by an employee if the injury incapacitates the employee from earning full wages for at least three (3) days or requires medical treatment, regardless of the period of incapacity.** If the injury proves fatal, the report must be filed within forty-eight (**48**) hours. If not fatal, the report shall be made within ten (10) days of the injury.

An injured employee shall have the freedom to choose medical treatment initially. The employee's first visit to any facility under contract or agreement with the employer or insurer to provide priority care **shall not be considered** the employee's initial choice.

For more information about Workers' Compensation procedures and benefits, call the Education Unit at (401) 462-8100 and press option #1 or TDD (401) 462-8006. If you suspect fraud, contact the Fraud Prevention Unit at (401) 462-8100 and press option #7.

In accordance with Rhode Island General Law § 28-29-13, this notice must be posted and maintained in conspicuous places where workers are employed. Fines may be imposed for noncompliance.

South Carolina
Workers' Compensation

000102 294/304 3 01

If you are injured on the job, you should:

1. Notify your employer at once. You can't receive benefits unless your employer knows you are injured.
2. Tell the doctor your employer sends you to that you are covered by Workers' Compensation.
3. Notify the Workers' Compensation Provider below or the South Carolina Workers' Compensation Commission at (803) 737-5700 if you experience undue delays or problems with your claim.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

We are operating under and subject to the

South Carolina Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

South Carolina Workers' Compensation Commission
P.O. Box 1715, 1333 Main Street, Suite 500
Columbia, S.C. 29202-1715
(803) 737-5700
www.wcc.sc.gov

Form WC 88 39 02 E Printed in U.S.A.

TENNESSEE WORKERS' COMPENSATION INSURANCE
POSTING NOTICE

How to Report Work-Related Injuries

What should be done if injured at work?

000102 295/304 3 01

Employee

1. Immediately **report the injury** to the employer representative named below.
2. **Select a treating physician** from a panel provided by your employer.
3. If you have questions or problems, contact the employer representative or the Bureau of Workers' Compensation.

Employer

1. Complete your company's internal "Workplace Injury form" and **notify your workers' compensation insurance company immediately**, even if you have concerns about the validity of the claim.
2. **Offer a panel of physicians** to the employee via Form C-42 available on the Bureau's website. In cases of emergency, call an ambulance and provide this form as soon as the injured employee has stabilized.

_____

*Printed **name and title** of the employer representative to be notified in the event of a work-related injury*

_____

*Printed name of an **alternative employer representative** to be notified in the event of a work-related injury*

_____

***Telephone number** of employer representative to notify in event of a work-related injury*

_____

***Address** of employer representative to notify in event of a work-related injury*

The Tennesse Bureau of Workers' Compensation is available to help both employees and employers.

Bureau of WORKERS' COMPENSATION

220 French Landing Dr. 1-B
Nashville, TN 37243-2667
800-332-2667
615-532-4812 *TTD: 800-332-2257*
tn.gov/workerscomp

Workers' Compensation law requires this notice to be posted in a conspicuous place at the work site at all times.

LB-0922 REV. (4/18) Authorization No. 337545 RDA 10183

Form WC 88 41 10 F Printed in U.S.A.

SEGURO DE COMPENSACIÓN A TRABAJADORES DE TENNESSEE

PUBLICACIÓN DE AVISO

Cómo informar de lesiones laborales

¿Qué se debe hacer en caso de lesión laboral?

Empleado

1. **Informe** inmediatamente de **la lesión** al representante del empleador indicado aquí abajo.
2. **Seleccione un médico tratante** del panel provisto por su empleador.
3. Si tiene alguna pregunta o problema, comuníquese con el representante de empleadores de la Oficina de Compensación a Trabajadores.

Empleador

1. Complete el formulario interno de su empresa de "Lesión laboral" y **notifique a su aseguradora de compensación a trabajadores** inmediatamente, incluso aunque tenga dudas acerca de la validez de la reclamación.
2. **Ofrezca un panel de médicos** al empleado a través del Formulario C-42, disponible en el sitio web de la Agencia. En casos de emergencia, llame a una ambulancia y proporcione este formulario en cuanto el empleado lesionado se haya estabilizado.

_____

***Nombre en letra de molde y título** del representante del empleador a ser notificado en caso de una lesión laboral*

_____

***Nombre en letra de molde del representante del empleador alterno** a ser notificado en caso de una lesion laboral*

_____

***Número de teléfono** del representante del empleador a ser notificado en caso de una lesión laboral*

_____

***Dirección** del representante del empleador a ser notificado en caso de una lesión laboral*

La Oficina de Compensación a Trabajadores de Tennessee está disponible para ayudar a empleados y empleadores.

Bureau of WORKERS' COMPENSATION

220 French Landing Dr. 1-B
Nashville, TN 37243-2667
800-332-2667
615-532-4812 TTD: 800-332-2257
tn.gov/workerscomp

La ley de Compensación a Trabajadores exige que se publique este aviso en un lugar visible en el centro de trabajo en todo momento.

LB-0922 REV. (4/18) Autorización No. 337545 RDA 10183

Form WC 88 41 11 F Printed in U.S.A.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA
[Name of employer]
has workers' compensation insurance coverage from Twin City Fire Insurance Company
[Name of commercial insurance company]
in the event of work-related injury or occupational disease. This coverage is effective from 07/31/21
[Effective date of workers' compensation insurance policy]
. Any injuries or occupational diseases which occur on or after that date will be handled by Twin City Fire Insurance Company
[Name of commercial insurance company]
. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Worker's Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24-hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

DO NOT POST THIS SIDE

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACION PARA TRABAJADORES EN TEXAS

000102 299/304 3 01

COBERTURA: TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA
[Name of employer]
tiene cobertura deseguros de compensación para trabajadores con Twin City Fire Insurance Company [Name of commercial insurance company] para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde 07/31/21 [Effective date of workers' compensation insurance policy]. Cualquier lesióno enfermedad ocupacional que ocurra en o después de esta fecha serámanejada por Twin City Fire Insurance Company [Name of commercial insurance company] Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

Continuacion en Pagina 2

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División. El infractor podría estar sujeto a sanciones administrativas.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

WORKERS' COMPENSATION NOTICE

Employer: TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

has complied with the provisions of the Workers' Compensation Act (§34A-2-101, Utah Code Annotated), the Utah Occupational Disease Act (§34A-3-101, Utah Code Annotated), and the rules of the Labor Commission by insuring the liability to pay the compensation and other benefits provided by said Acts through:

Insurance Company: Twin City Fire Insurance Company

Policy Number: 10 WB AT1140

Address for the above insurance company:

Northbelt II ? 785 Greens Pkwy, Ste 210, Houston, TX 77067

Telephone number (800)-327-3636

☐ Check here if the employer has been authorized by the Division of Industrial Accidents to self-insure and directly pay workers' compensation benefits.

000102 302/304 3 01

WORKERS' COMPENSATION

Workers' Compensation is insurance which pays medical expenses and helps offset lost wages for employees with work-related injuries or illnesses. If you have an on-the-job injury or occupational disease, it may pay for: hospital and medical bills, time lost from work, permanent loss of body function, prosthetic devices, and burial and dependent benefits in case of death.

HOW TO REPORT AN ACCIDENT

1. Report the injury, no matter how slight, immediately to your supervisor. You may lose your rights if your injury is not reported within 180 days of the injury or work-related illness.
2. Ask your employer where you should go for treatment. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.
3. Tell the doctor **HOW, WHEN and WHERE** the accident happened. The doctor will fill out a physician's initial report form. A copy of the report is given to you and copies of the report are sent to the insurance company and the Labor Commission within seven (7) days of your doctor visit.
4. Your employer shall fill out the employer's first report of injury form. A copy of this report is sent to the insurance company within seven (7) days of the accident. The insurance company will report the injury to the Labor Commission.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation benefits for the company.
2. Ask your employer to report the accident to the insurance company and give you the claim number.
3. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the employer's report, the physician's report, and may ask you to fill out a request for compensation. Cooperate with the adjuster's investigation of the injury.
4. Ask your doctor to send medical reports to the insurance company, including the work status statement.

REHABILITATION

If you cannot return to work, you may be eligible for a rehabilitation program. Contact the insurance company listed above or the Utah State Office of Rehabilitation.

FRAUD STATEMENT: "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

UTAH
LABOR COMMISSION
Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

If you want copy of an *Employee's Guide to Workers' Compensation* booklet or have questions, contact the Labor Commission or go to the webpage at www.laborcommission.utah.gov.

Note: This notice must be posted and kept continuously in public and conspicuous places in the office, shop or place of business of the employer as per §34A-2-204 and §34A-2-104.5, Utah Code Annotated.

Form VWC1

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

   NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, Virginia 23220

1-877-664-2566
vwc.state.va.us

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

Form WC 88 45 02 C Printed in U.S.A.

NOTICE

WORKERS' COMPENSATION ACCIDENT REPORTING

You Have Workers' Compensation Insurance with THE HARTFORD

WHEN AN EMPLOYEE IS INJURED ON THE JOB, OR DOES NOT REPORT FOR WORK:

1. **Inquire as to cause of absence, if unknown.**

2. **If employee is injured on the job, or, if absence may be due to injury or illness related to employment:**

   a. **Provide proper medical attention.**

   b. **Complete the Employer's First Report of Injury or Disease form in duplicate at once. This form can be obtained from the following website: dwd.wisconsin.gov/dwd/forms/wkc/WKC_12_E.htm.**

   c. **Mail original immediately to:**

      Twin City Fire Insurance Company
      4245 Meridian Parkway
      Aurora IL 60504

   d. **If employee is, or will be, off work more than three days, mail copy to:**

      Department Of Workforce Development
      Workers' Compensation Division
      P.O. Box 7901
      Madison, Wisconsin 53707-7901

VERMONT

DEPARTMENT OF LABOR

Employer's Liability and Workers' Compensation

NOTICE TO EMPLOYEES

This employer, TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA **, has complied with the provisions of Title 21 of the Vermont Statutes, Annotated §687, by obtaining Workers' Compensation Insurance coverage through:**

TWIN CITY FIRE INSURANCE CO.

(Insurance Carrier)

Workers' Compensation benefits for lost time, medical expenses, disability or death because of a work-related injury are available through the above named company.

- **An injured employee MUST immediately notify his/her employer of an injury.**
- **The employer MUST file an Employee Claim and Employer's First Report of Injury (Form 1) with the Vermont Department of Labor within 72 hours of the notice of an injury that requires medical attention or results in time lost from work. The employer must also provide a copy of the Form 1 to the injured worker and to the insurance carrier.**
- **If the employer fails to file a First Report, an employee may file a Notice of Injury and Claim for Compensation (Form 5) with the Vermont Department of Labor within six months of the date of injury.**
- **Information concerning injured worker rights and benefits is available on the department's Workers' Compensation website at http://www.labor.vermont.gov or by calling (802) 828-2286.**

Equal Opportunity is the Law

The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711 (TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).

WC-10 (12/05)

WC-88-44-01-C Printed in U.S.A.

FORM 17 Revised 11/2014

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

The Employee Should:

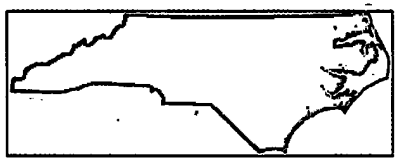
- **Report the injury or occupational disease to the Employer immediately.**
- **Give written notice to the Employer within 30 days.**
- **File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.**
- **If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.**
- **Your employer's workers' compensation insurance carrier is** TWIN CITY FIRE INSURANCE CO.
- **The insurance policy number is** 10 WB AT1140
- **Your employer's workers' compensation insurance policy is valid from** 07/31/21 **until** 07/31/22

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

- **Provide all necessary medical services to the Employee.**
- **Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $2,000.00.**
- **Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.**
- **Ensure that compensation is promptly paid as required under the Workers' Compensation Act.**

For assistance with Safety Education Training contact:
Director of Safety Education at (919) 807-2602 or safety@ic.nc.gov



NORTH CAROLINA INDUSTRIAL COMMISSION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335

Website: www.ic.nc.gov

TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat. §97-93).

DISTRICT OF COLUMBIA GOVERNMENT
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION

PO BOX 56098 • WASHINGTON, DC 20011 • (202) 671-1000 • (202) 671-1929 (fax)

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalities include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law to report promptly to your employer and the Office of Workers' Compensation an occupational injury or disease, even if you deem it to be minor. Form No. 7 DCWC, Notice of Accidental Injury or Occupational Disease, to be obtained from the employer or the Office of Workers' Compensation, must be used for that purpose. After you have completed and signed it, you should mail it to the Office of Workers' Compensation at the above address, and to your employer.

2. You are entitled, if required, to the services of a physician or hospital of your choice and lost wages. Call (202) 671-1000 for information.

3. You may not sue your employer as a result of a work-connected injury or disease by reason of your exclusive remedy under the Workers' Compensation Law.

4. In order to preserve your right to benefits under the DC Workers' Compensation Law, you must file a written claim on Form No. 7A DCWC, Employee's Claim Application, within one (1) year after your injury, or within (1) year after the last payment of benefits.

5. If you desire information regarding your rights and obligations prescribed by law, you may call your employer first. If you need further information you may call the Office of Workers' Compensation at (202) 671-1000.

6. The law gives you the right to be represented if you so desire.

TO EMPLOYERS

1. You are required to have Workers' Compensation insurance coverage if you have 1 or more employees.

2. You are required to display this poster at each worksite so that it will be of the greatest possible benefit to your employees.

3. You must file an Employer's First Report of Injury or Occupational Disease, Form No. 8 DCWC, with the Office of Workers' Compensation, copy to the nearest claim office of your insurer, on all occupational injuries or disease, as soon as possible, but no later than 10 days after the date of knowledge thereof.

4. Your employee must file Form No. 7 DCWC, Employee's Notice of Accidental Injury or Occupational Disease. Please provide your employee with Form No. 7 DCWC and direct them to complete it and return it to you and the Office of Workers' Compensation. Once you have received notice from the employee, you are required to send the employee a notice of his/her rights and obligations by certified mail, return receipt requested.

5. You are required to report to the Office of Workers' Compensation, and your insurer, and disability of more than 3 days which was not previously reported, as soon as possible, but no later than 10 days after the date of knowledge thereof.

6. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee.

7. You are required to obtain from the insurer identified below a supply of all required Workers' Compensation Forms, or you may download the forms and notice mentioned above at our website http://does.dc.gov

NOTICE: Violation of the various provisions of the Workers' Compensation law provides for civil penalties.

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations

NAME OF INSURANCE COMPANY

TWIN CITY FIRE INSURANCE CO.
3600 WISEMAN BLVD
SAN ANTONIO TX 78251
07/31/22

NAME OF EMPLOYER

BY TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

23-1352685

Employer ID Number
(if number unknown, employer to request from IRS)

THIS NOTICE IS TO BE POSTED CONSPICUOUSLY IN AND ABOUT EMPLOYER'S PLACE(S) OF BUSINESS

FORM NO. 1 DCWC Revised June, 2002

Form WC 88 08 01 A Printed in U.S.A.

WORKERS' COMPENSATION in Maryland
LA COMPENSACIÓN DEL TRABAJADOR en

Job Related Accidental Personal Injury or Occupational Disease?

If you are disabled and unable to work for more than three (3) days, your employer's workers' compensation insurance company may pay your medical bills and other expenses and replace two-thirds (2/3) of your salary (limited to the maximum set by law).

If you are injured on the job:

1. Notify your employer or supervisor at once. You cannot receive full benefits unless your employer knows you are injured.
2. Tell the doctor who treats you that you were hurt on the job.
3. Complete an Employee's Claim Form C-1 (available by phone or on the Commission's website) and send it to us as soon as possible.

Note: Withholding information or giving false information about any work-related activity or return to work could prevent you from receiving benefits and may subject you to fines, imprisonment or both.

Employer/Empleador TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

Business Address/Dirección 2929 WALNUT ST STE 460

City/State/Zip
Ciudad/Estado/Código Postal PHILADELPHIA PA 19104-5099

Federal Employer ID (FEIN)
Identificación Federal Del Empleador 23-1352685

Telephone Number/Número Telefónico

Insurance Company Name
La Compañía de Seguro TWIN CITY FIRE INSURANCE CO.

Insurance Company Telephone
Teléfonico de la Compañía de Seguro 800-327-3636

MD WCC Form C-24 11/2007

WC 88 19 09 A Printed in U.S.A.

¿Accidentes por lesión/daño corporal relacionados con el Empleo o Enfermedad Profesional?

Si usted se encuentra incapacitado o inhabilitado para trabajar por más de tres días, el seguro de trabajadores que tienen las compañías pudiera cubrir las facturas médicas y otros gastos relacionados. También le compensarían 2/3 de sus ingresos (Hasta un monto máximo estipulado por la ley).

Si usted sufre una lesión en el trabajo, debe:

1. Informarle a su empleador o supervisor de inmediato. No podría recibir todos sus beneficios a menos que su empleador fuere notificado que sufrió una lesión.
2. Informarle al médico quien le administre tratamiento que usted se lesionó en su trabajo.
3. Llenar el formulario Employee's Claim Form C-1 (disponible consultando la página del Internet para el Workers' Compensation o solicitándo uno por teléfono). Diligenciarlo para que las oficinas del Workers' Compensation lo reciban lo antes posible.

Aviso: El suministrar información falsa u ocultar información sobre cualquier actividad relacionada con su trabajo o relacionada con su regreso al trabajo, pudiera afectar los beneficios que recibiera o pudiera acarrearle multas, encarcelamiento o ambas.

Maryland Workers' Compensation Commission
10 East Baltimore Street, Baltimore, Maryland 21202-1641
(410) 864-5100 / Outside Baltimore (800) 492-0479
Webpage - http://www.wcc.state.md.us / TTY Users - 711 in Maryland or (800) 735-2258

This notice must be printed on 8.5 "X 14" gold or yellow paper, display complete employer information and be posted in a conspicuous location at each work site or location in accordance with COMAR 14.09.01.02 and 14.09.01.03.

00073344

Workers' Compensation Exemptions

Construction Industry

An employer in the construction industry who employs one or more part-time or full-time employees, including the owner, must obtain workers' compensation coverage.

Corporate officers or members of a limited liability company (LLC) in the construction industry may elect to be exempt if:

- The officer owns at least 10 percent of the stock of the corporation, or in the case of an LLC, a statement attesting to the minimum 10-percent ownership.
- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

No more than three corporate officers per corporation or limited liability member are allowed to be exempt. A $50 fee is required for each application submitted to obtain an exemption. Construction exemptions are valid for a period of two years or until a voluntary revocation is filed or the exemption is revoked by the Division.

Non-Construction Industry

An employer in the non-construction industry, who employs four or more part-time or full-time employees, must obtain workers' compensation coverage.

Sole proprietors and partners in the non-construction industry are automatically exempt from the law, but can elect to be covered.

Non-construction industry corporate officers may elect to be exempt if:

- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

There is no limit to the number of corporate officers who can be exempt and there is no application fee. Non-construction exemptions are valid until a voluntary revocation is filed or the exemption is revoked by the Division.

For copies of the exemption form, contact the Division's Bureau of Compliance at (850) 413-1609 or go to http://www.MyFloridaCFO.com/WC/forms.html and click on Rule 69L-6 and Form number DWC-250, Notice of Election to Be Exempt.

What Your Employee Can Expect From the Insurance Carrier

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of the employee's claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of the employee's claim. This information should be provided to the injured worker by mail on either a Notice of Action/ Change form (DWC-4) or a Notice of Denial form (DWC-12)

Questions about workers' compensation?

Please visit our Web site at www.MyFloridaCFO.com/wc where you will find extensive information such as publications, databases, rules and forms that will give you a better understanding of workers' compensation.

Employee Assistance and Ombudsman Office Hotline
1-800-342-1741

Injured worker e-mail inquiries
wceao@MyFloridaCFO.com

Customer Service
(850) 413-1601

Employer e-mail inquiries
WorkCompCustServ@MyFloridaCFO.com

Workers' Compensation Fraud Hotline
1-800-378-0445

Frequently Asked Questions

Q) How many days do employees have to report work-related injuries or illnesses?

A) Employers should encourage employees to report accidents as soon as the work related injuries or illnesses occur. By law, however, employees are required to report work related injuries or illnesses within 30 days.

Q To whom should I report the work-related injury?

A) You should report the accident to your insurance company as soon as you have knowledge of the injury.
By law, you have seven days from your first knowledge of the work related injury.

Q) Do I have to report a claim if I do not believe it is a work-related injury or illness?

A) Yes. You should report all claims of work-related injuries or illnesses to your workers' compensation insurance carrier. This includes claims in which there are no witnesses of the injury or illness. It is your workers' compensation insurance carrier's responsibility to investigate all claims and determine if employees are entitled to benefits under Florida's Workers' Compensation Law.

Q) Does the employee pay any part of my workers' compensation insurance premium?

A) No. The law is very specific on this point. It is the employer's responsibility to pay the entire premium for workers' compensation.

Employers who secure workers' compensation coverage can also apply to become a drug-free workplace and may receive a premium discount. To learn more about the Drug-free Workplace Program, please call the Division of Workers' Compensation Customer Service Office at 850-413-1609.

Q) Who should I call if my employees have questions or concerns regarding their workers compensation claims?

A) You should first contact your insurance carrier. If your carrier is unable to answer the question or resolve the problem, you or your employees should call the Employee Assistance and Ombudsman Office at 1-800-342-1741.

Disclaimer:
This publication is being offered as an informational tool only and complies with s. 440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-65
Revised March 2010

Form WC 88 09 17 C

EMPLOYER FACTS

IMPORTANT

WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S EMPLOYERS

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

Your workers' compensation insurance policy covers medical and partial wage-replacement benefits for any employee who sustains a work related injury or illness.

This brochure will give you a better understanding of your role and responsibilities under the workers' compensation system.

Workers' Compensation Notice

The law requires that every employer who has secured workers' compensation coverage post in conspicuous place(s) a notice that contains the employer's insurance carrier information, the expiration date of the policy and an anti-fraud statement. The Division of Workers' Compensation has developed this notice, in poster form, for carriers to provide to their policyholders. Your carrier is required by law to provide you with the poster(s).

Even if employers have purchased workers' compensation policies, they shall be deemed to have failed to secure workers' compensation coverage if they have committed any of the following actions:

- materially understated or concealed payroll,
- materially misrepresented or concealed employee duties to avoid proper classification for premium calculations, or
- materially misrepresented or concealed information pertinent to the computation and application of an experience modification factor.

Employers who fail to secure workers' compensation coverage or fail to update information on their workers' compensation insurance application are subject to stop work orders and civil and criminal penalties.

First Report of Injury

As soon as you become aware of a work-related injury or illness, immediately contact your workers' compensation insurance carrier. If you do not report the injury or illness to your insurance carrier within seven days of the date you were informed, you may be subject to an administrative fine not to exceed $2,000 per occurrence. Most insurance companies have a toll-free number to report work-related injuries. If you report the injury or illness to the insurance carrier by telephone, the carrier will complete the form and send a copy to you and the employee within three business days. You can also fill out the First Report of Injury or Illness form (DWC-1) and send it to the insurance carrier. The form contains employer, employee and accident information and can be obtained on the Division of Workers' Compensation Web site at www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1.pdf. You must also provide a copy of the First Report of Injury or Illness form to the employee. The employee's signature on the form is preferred, but if the employee is not able or available to sign it, then write "not available" in the employee signature box.

Workplace Fatalities

Employers must also report deaths resulting from work-related injuries or illnesses to the Division of Workers' Compensation within 24 hours. To report a workplace fatality, call 1-800-219-8953 (in Florida) or 850-413-1611, or fax the First Report of Injury of Illness form containing the fatality information to 850-413-1980. To access the form, go to http://www.MyFloridaCFO.com/WC/forms.html and click on DWC-1.

Medical Benefits

As soon as you notify your carrier about your employee's work-related injury, the carrier will:

- Determine the compensability of the injury
- Provide an authorized doctor
- Pay for all authorized medically necessary care and treatment related to the injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor's visits
- Hospitalization
- Physical therapy
- Medical tests
- Prescription drugs
- Prostheses
- Travel expenses to and from authorized providers or pharmacies.

Upon reaching maximum medical improvement (MMI), the employee is required to pay a $10 copayment per visit for medical treatment. MMI occurs when the treating physician determines that the employee's injury has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

Workers' compensation benefits for lost wages will start on the eighth day that the injured employee is unable to work. The injured employee will not receive wage replacement benefits for the first seven days of work missed, unless he or she is out of work for more than 21 days due to the work-related injury. In most cases, the wage-replacement benefits will equal two-thirds of the employee's pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. If the employee qualifies for wage replacement benefits, he or she can expect to receive the first benefit check within 21 days after the carrier becomes aware of the injury or illness, and bi-weekly thereafter. The injured employee will be eligible for different types of wage replacement benefits, depending on the progress of the claim and the severity of the injury.

- Temporary Total Benefits: These benefits are provided as a result of an injury that temporarily prevents the employee returning to work and the employee has not reached MMI.
- Temporary Partial Benefits: These benefits are provided when the doctor releases the employee to return to work, and the employee has not reached MMI and earns less than 80 percent of the pre-injury wage. The benefit is equal to 80 percent of the difference between 80 percent of the pre-injury wage and the post-injury wage. The maximum length of time the injured employee can receive temporary benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.
- Permanent Impairment Benefits: These benefits are provided when the injury causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole. If you return to work at or above your pre-injury wage, the permanent impairment benefit is reduced by 50%.
- Permanent Total Benefits: These benefits are provided when the injury causes the employee to be permanently and totally disabled according to the conditions stated in law.
- Death Benefits: Compensation for deaths resulting from work-related injuries or illnesses include payment of funeral expenses and dependency benefits (each are subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

Wage Statement Form

You must complete and provide a wage statement form (DFS-F2-DWC-1a) to your carrier for any employee who is entitled to wage replacement benefits, within 14 days after knowledge of the accident. You must also complete this form upon the termination of the employee or upon termination of fringe benefits for any employee who is collecting wage replacement benefits within seven days of such termination. To access the form go to, http://www.MyFloridaCFO.com/WC/forms.html and click on DWC-1a.

Employee Assistance Office

If you have any questions or concerns about your employees' workers' compensation benefits, call your workers' compensation insurance carrier. If the insurance carrier does not provide the information that you have requested, you can call the Division of Workers' Compensation, Employee Assistance Office (EAO) at 1-800-342-1741. This office helps prevent and resolve disputes between injured workers and employers/carriers.

EAO specialists are knowledgeable about the workers' compensation system and may be able to answer your questions. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at www.MyFloridaCFO.com/WC/organization/eao_offices.html.

In addition, the Division of Workers' Compensation has a Web site section on "Frequently Asked Questions for Employers," which can be accessed at http://www.MyFloridaCFO.com/WC/faq/faqemplyrs.html.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/jcc/forms/.asp.

Anti-Fraud Reward Program

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program, files false or misleading information. Workers' compensation fraud is a third degree felony that can result in fines, civil liability and jail time. Rewards of up to $25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call 1-800-378-0445.

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

ATTENTION

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775)684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http:/govcha.state.nv.us, E-mail cha@govcha.state.nv.us

The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator: TWIN CITY FIRE INSURANCE CO. Contact Person: _____

Address: LAS VEGAS (City) NV (State) 89119 (Zip) Telephone Number: 800-327-3636

MCO/Health Care Provider: _____ Contact Person: _____

Address: _____ (City) _____ (State) _____ (Zip) Telephone Number: _____

D-1 (rev. 10/07)

Form WC 88 27 00 F Printed in U.S.A.

State of New Mexico Workers' Compensation Administration

WORKERS' COMPENSATION ACT

If You Are Injured At Work
Si Se Lastima En El Trabajo

1) Notice -- In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form.

2) You have the right to information and assistance from an information specialist known as an "Ombudsman" at the Workers' Compensation Administration.

3) Claims information -- Contact your employer's Claims Representative.

1) Aviso. -- En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.

2) Usted tiene el derecho a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.

3) Información acerca de Reclamaciones. -- Contáctese con el representante de reclamaciones de su compañía.

Employer's Insurer / Claims Representative:

Name: TWIN CITY FIRE INSURANCE CO.

Phone #: 800-327-3636

Address: NORTHBELT II ? 785 GREENS PKWY, STE 210

HOUSTON, TX 77067-4409

Note: Employer must fill in this insurer / claims representative information.

YOUR RIGHTS

If you are injured in a work-related accident:

Your employer / insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer / insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency, get emergency medical care first.

If you are off work for more than seven days, your employer / insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

SUS DERECHOS

Si se lastima en el trabajo:

Su empleador / asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador / asegurador no le ha dado instrucciones por escrito de quien es él que selecciona primero, pregúntele o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador / asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un periodo de tiempo más largo.

Ombudsmen are located at the following offices:

Albuquerque:	Farmington:	Hobbs:	Las Cruces:	Las Vegas:	Roswell:	Santa Fe:
1-866-967-5667	1-800-568-7310	1-800-934-2450	1-800-870-6826	1-800-281-7889	1-866-311-8587	1-505-476-7381
1-505-841-6000	1-505-599-9746	1-575-397-3425	1-575-524-6246	1-505-454-9251	1-575-623-3997	

If You Need HELP Call:

Ask for an Ombudsman

Si Usted Necesita Ayuda Llame Al:

Pregunte por un Ombudsman

1 - 8 6 6 - W O R K O M P (1-866-967-5667)

Visit our website at: https://workerscomp.nm.gov

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667

USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR

EMPLOYER: You are required by law to post this poster where your employees can read it and to post Notice of Accident forms with it. This poster without Notice of Accident forms does not comply with law. You have other rights and duties under the law.

New Mexico Workers' Compensation Administration
2410 Centre Avenue, Albuquerque, New Mexico 87106
PO Box 27198, Albuquerque, New Mexico 87125-7198

This poster published 7/18.

POST FORMS HERE

Form WC 88 30 05 D Printed in U.S.A

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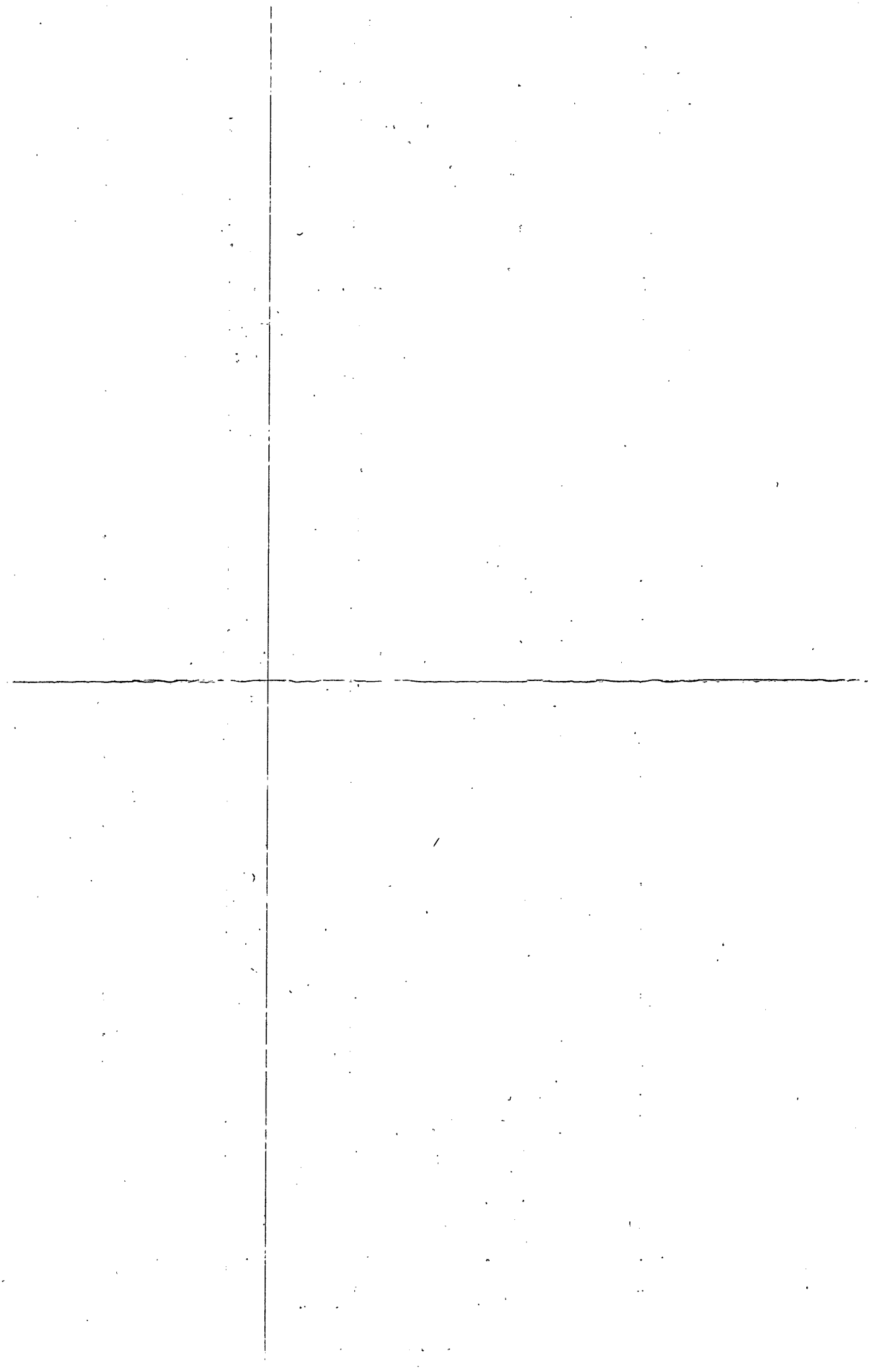
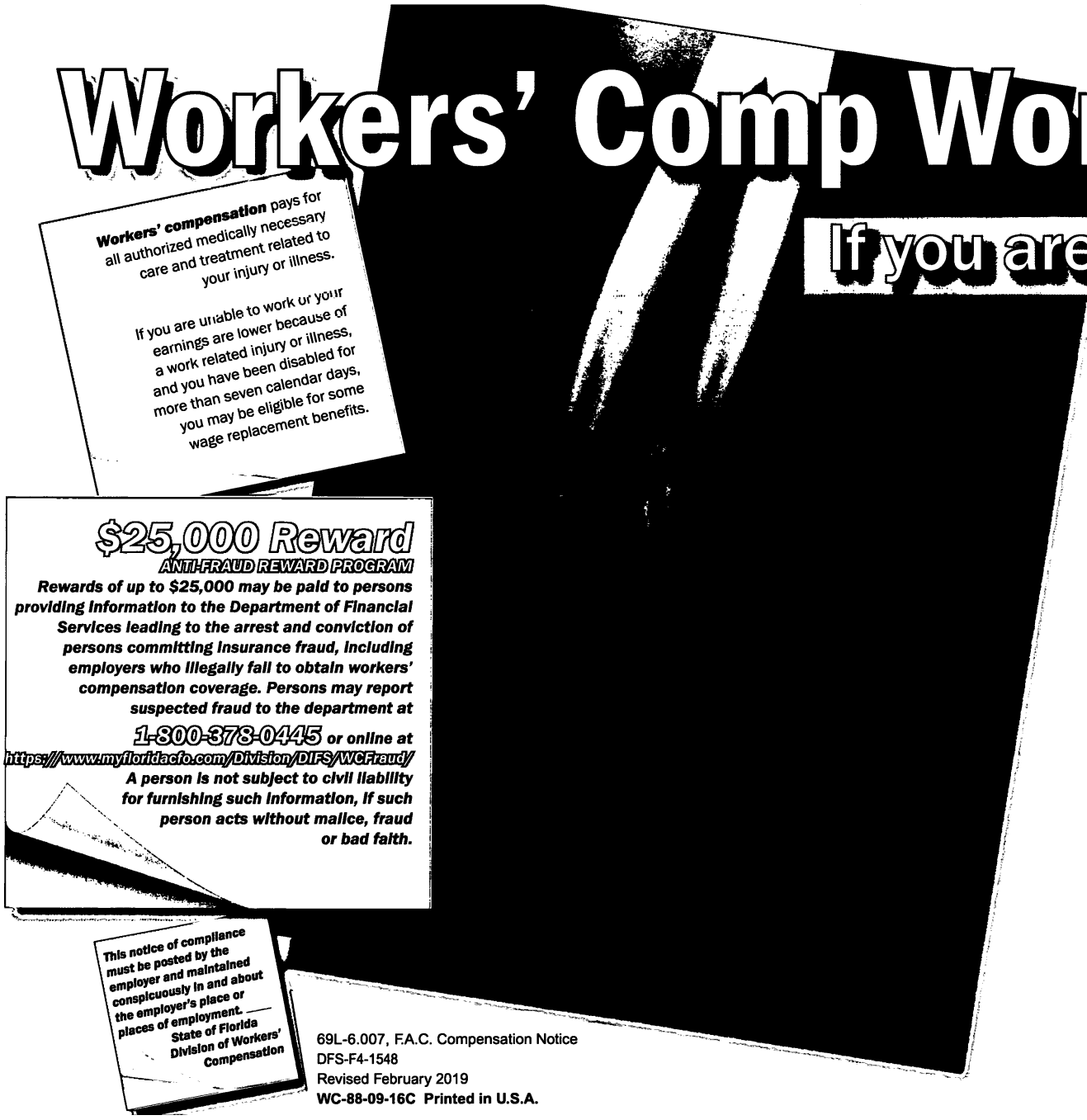


Workers' Comp Works For You



Workers' compensation pays for all authorized medically necessary care and treatment related to your injury or illness.

If you are unable to work or your earnings are lower because of a work related injury or illness, and you have been disabled for more than seven calendar days, you may be eligible for some wage replacement benefits.

$25,000 Reward

ANTI-FRAUD REWARD PROGRAM

Rewards of up to $25,000 may be paid to persons providing information to the Department of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the department at

1-800-378-0445 or online at https://www.myfloridacfo.com/Division/DIFS/WCFraud/

A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.

This notice of compliance must be posted by the employer and maintained conspicuously in and about the employer's place or places of employment.
State of Florida
Division of Workers' Compensation

69L-6.007, F.A.C. Compensation Notice
DFS-F4-1548
Revised February 2019
WC-88-09-16C Printed in U.S.A.

If you are injured on the job:

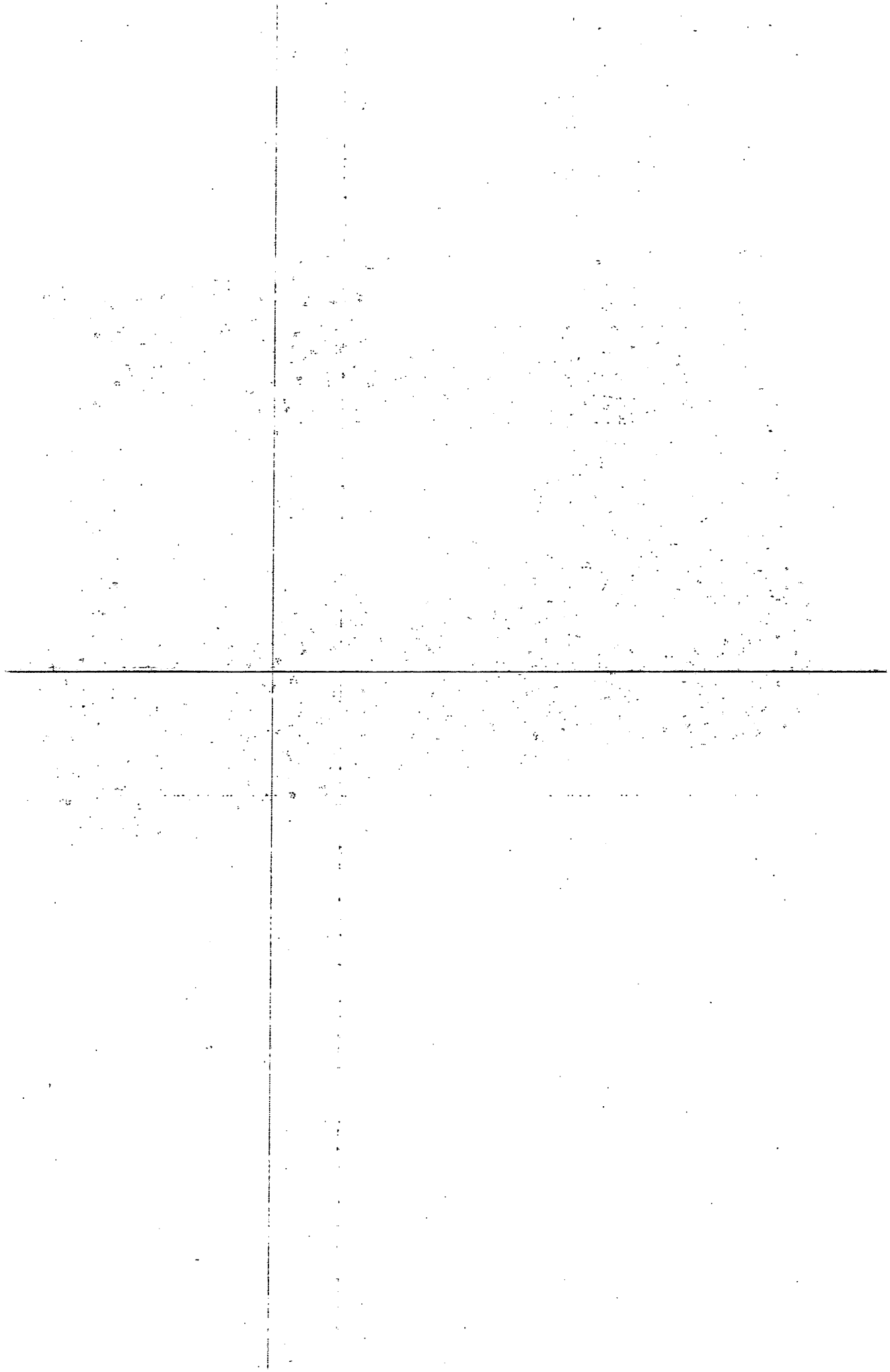
1. **Notify your employer immediately to get the name of an approved physician. Workers' comp insurance may not pay the medical bills if you don't report your injury promptly to your employer.**

2. **Notify the doctor and medical staff that you were injured on the job so that bills may be properly filed.**

3. **If you have any problems with your claim or suffer excessive delays in treatment, contact the State of Florida's Division of Workers' Compensation at 1-800-342-1741.**

EMPLOYER - NAME:	TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA
Address:	2929 WALNUT ST STE 460
	PHILADELPHIA PA 19104-5099
INSURER - NAME:	TWIN CITY FIRE INSURANCE COMPANY
Address:	200 COLONIAL CENTER PKWY, SUITE 500
	LAKE MARY FL 32746
Policy Number:	10 WB AT1140
Effective Date:	07/31/21 Expiration Date: 07/31/22

BRCC # 00230455



COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Información De Indemnización Por Accidentes Laborales De Colorado

Su empleador tiene cobertura de indemnización por accidentes laborales para empleados completamente:

TWIN CITY FIRE INSURANCE CO.

La indemnización por accidentes laborales es un tipo de cobertura de seguro que los empleadores deben proveer a sus empleados. El coste del seguro de indemnización por accidentes laborales es pagado completamente por el empleador y no puede ser deducido de los sueldos de un empleado.

Si usted sufrió un accidente o mantiene una enfermedad profesional en su trabajo, usted puede calificar para los beneficios de compensación. Usted tiene la obligación de NOTIFICAR POR ESCRITO A SU EMPLEADOR DENTRO DE 4 DÍAS DEL ACCIDENTE. Si usted no informa sobre su accidente o enfermedad profesional inmediatamente sus beneficios podrían ser reducidos.

Si usted no puede trabajar por el resultado de su accidente de trabajo o la enfermedad profesional, los beneficios de compensación serán pagados sobre la base de 2/3 de su sueldo semanal hasta un máximo fijado por ley. Los primeros 3 dias no son cubiertos por la aseguranza.

Usted está autorizado para el tratamiento médico que sea razonable y necesario si usted sufrió lesiones en el trabajo o enfermedades profesionales. Si usted notifica a su empleador sobre una lesión o la enfermedad profesional y no le ofrecen atención médica adecuada, usted puede seleccionar los servicios de otro médico que tenga licencia o que sea quiropráctico.

Usted puede reportar su propio reclamo si su empleador no lo ha hecho. Para obtener formularios o información acerca de accidentes laborales usted puede puede llamar al servicio de asistencia al numero 303-318-8700 o sin costo a 1-888-390-7936 o visitar nuestro sitio web en www.colorado.gov/cdle/dwc.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
633 17th St. Suite 400, Denver, CO 80202-3660

Cualquier información proveída abajo viene directamente de su empleador y es exclusivo de este lugar del empleo:

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Colorado Workers' Compensation Information

Your employer has workers' compensation coverage for employees through:

TWIN CITY FIRE INSURANCE CO.

Workers' compensation is a type of insurance coverage that employers must provide to their employees. The cost of workers' compensation insurance is paid entirely by the employer and may not be deducted from an employee's wages.

If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT. If you don't report your injury or occupational disease promptly your benefits may be reduced.

If you are unable to work as the result of a work-related injury or occupational disease, compensation (wage replacement) benefits will be based on 2/3 of your average weekly wage up to a maximum set by law. No compensation is payable for the first 3 days' disability unless the period of disability exceeds two weeks.

You are entitled to reasonable and necessary medical treatment of compensable injuries or occupational diseases. If you notify your employer of an injury or occupational disease and are not offered medical care, you may select the services of a licensed physician or chiropractor.

You may file a Worker's Claim for Compensation with the Division of Workers' Compensation. To obtain forms or information regarding the workers' compensation system, you may call Customer Service at 303-318-8700 or toll-free at 1-888-390-7936 or visit our website at www.colorado.gov/cdle/dwc.

COLORADO DIVISION OF WORKERS' COMPENSATION
633 17th Street, Suite 400, Denver, CO 80202-3626

Any information provided below comes from your employer and is specific to this place of employment:

WARNING

IF YOU ARE INJURED ON THE JOB, WRITTEN NOTICE OF YOUR INJURY MUST BE GIVEN TO YOUR EMPLOYER WITHIN FOUR DAYS AFTER THE ACCIDENT, PURSUANT TO SECTION 8-43-102(1) AND (1.5), COLORADO REVISED STATUTES.

IF THE INJURY RESULTS FROM YOUR USE OF ALCOHOL OR CONTROLLED SUBSTANCES, YOUR WORKERS' COMPENSATION DISABILITY BENEFITS MAY BE REDUCED BY ONE-HALF IN ACCORDANCE WITH SECTION 8-42-112.5, COLORADO REVISED STATUTES.

No. WCSD Rev. 7-99 NOTICE TO EMPLOYER OF INJURY
Form WC 88 05 05 A Printed in U.S.A. **00073350**