



YOUR WORKERS' COMPENSATION POLICY GUIDE District of Columbia

Thank you for choosing Builders Mutual Insurance Company as your commercial insurance carrier. As the industry experts, we pride ourselves in providing top notch service and products to our policyholders. For more than thirty years, we have been known as the company “where builders come first” and our goal is to exceed that expectation.

We look forward to serving you and appreciate your business. Enclosed is your workers’ compensation policy; please read carefully and retain for your records. If you have any questions about this policy or any other matter related to Builders Mutual – please contact your Agent or our Company.

CUSTOMER CONTACT CENTER: (800) 809-4859
REPORT A CLAIM: (800) 809-4862
MANAGE YOUR CLAIM: (800) 809-4861

We appreciate the opportunity to meet your commercial insurance needs and look forward to servicing your future insurance needs.

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Also enclosed in this policy jacket:

Your Policy
Post Injury Drug/Alcohol Policy (post for employees)
BMIC Drug Testing Acknowledgement
Estimated Billing (invoice for any premium due)

PREMIUM ACCOUNTING

Payment Plans

Builders Mutual offers the following payment plans; policyholders may change plans at renewal only:

Monthly Self-Reporting

We know your payroll fluctuates throughout the year. With our convenient system of monthly reporting, your monthly premium is based on your actual payroll for the previous month. Policyholders will receive a monthly worksheet. Enter GROSS payroll by classification(s) for the period during the month coverage was in effect. If you did not have payroll during a month, mark "NO PAYROLL" on the report. Completed reports should be submitted with the appropriate premium payment to Builders Mutual by the 20th of each month.

- Online Monthly Self-Reporting is available on Builders Online Business. Simply login to BOB, enter your payroll and let the system calculate the amount due. Make an online payment to complete the process.
- Paper worksheets can be mailed to BMIC, PO Box 900017, Raleigh, NC 27675-00017 or emailed to: premiumaccounting@bmico.com.

Monthly Bill 10-Pay

For those whose annual premium is greater than \$1,000, have steady payroll and want a fixed payment plan. This plan allows for 20% of the total amount (premium + expense constant) to be due at application and we will bill for the remaining 9 installments.

4-Pay, Quarterly

For those whose annual premium is greater than \$1,000. This plan allows for 25% of the total amount (premium + expense constant) to be due at application. We will bill for the remaining 3 installments.

2-Pay, Semi-Annual

For those whose annual premium is greater than \$1,000. This plan allows for %50 of the total amount (premium + expense constant) to be due at application. We will bill for the remaining installment.

Annual

Policies that are less than \$1,000 in annual premium are required to be on the annual pay plan. In addition, policyholders who wish to pay one annual premium may select this plan. No deposit is required.

How to pay your bill

By mail: Send your remittance coupon along with your check to:
Builders Mutual Insurance Company
PO Box 900027, Raleigh, NC 27675-0027

By phone: To pay with credit/debit card, or electronic check, call our **Customer Contact Center at (800) 809-4859**. This toll-free payment option is available Monday-Friday, 8am to 6pm EST.

Online: Use this option to pay with a credit/debit card, or electronic check from your bank account. Go to Builders Online Business to pay your bill:
www.buildersmutual.com/policyholders

Go Paperless

Once you create an account with Builders Online Business, you can choose to Go Paperless and receive your policy documents via email.

Returned Checks

All checks that are returned for insufficient funds or any other reasons will subject the policyholder to a \$25.00 charge per check.

Renewals

The policy will renew on the renewal date listed on the declaration page. However, policies that incur losses are subject to review by BMIC's Underwriting department for continued acceptability.

Cancellation

Should a policyholder request the cancellation of its workers' compensation policy prior to its renewal date, there will be a short rate penalty assessed according to the National Council on Compensation Insurance (NCCI) table. Please contact your agent for more details.

Termination - Policyholder's Request

Requests for termination of coverage must be received in writing by BMIC and must include:

- Signature of an Owner or Officer
- Reason for Termination

Termination - Duplicate Coverage

In the event that a policyholder replaces coverage with a new carrier, the policyholder must send proof of coverage (letter of assumption or copy of new policy) in order to cancel the BMIC policy on the effective date of the new coverage.

PREMIUM AUDIT

The premium shown on your policy is an estimate based on your business's classifications and premium basis at the time your policy is issued. An audit will be conducted at the conclusion of the policy period to determine the "final" audited premium using the actual premium basis and classifications that apply to your business covered by this policy. You may be contacted by a BMIC representative to conduct a physical onsite audit of your financial records or you may be requested to voluntarily submit information to BMIC to determine the "final" premium. Completing the audit helps to ensure you are paying the right price for your Builders Mutual insurance coverage. Your failure to cooperate with any audit request may result in BMIC estimating your final premium.

Variables affecting your audit

Classifications

If at any time you have questions about properly classifying your operations, please contact us at (800) 809-4859. General audit information is available at www.buildersmutual.com/audit.

Subcontractors

Subcontractors can represent an additional exposure to loss for you and the insurance company. Policyholders are required to pay premiums for all uninsured subcontractors, whether or not they have fewer than three employees. The following information outlines premium determination for subcontractors.

Workers' Compensation

Policyholders will not be charged for the payroll of subcontractors if they provide Certificates of Insurance for subcontractors to Builders Mutual at the time of the audit. Without a Certificate of Insurance the amount paid to the subcontractors will be treated as remuneration and a premium charge will be made. This requirement includes subcontractors who do not have employees.

Subcontractor waivers are *not* accepted.

Your records

As a business owner, you know the importance of keeping accurate records. After the expiration of each policy period, a Builders Mutual auditor will contact you for an appointment. Remember, records that are properly maintained allow for a fair audit to be completed.

When it's time for your annual audit, the following records will be required by your auditor:

- Cash disbursement journal showing monthly totals for:
 - (1) materials
 - (2) subcontractors
 - (3) cash payments to individuals or day laborers not included in your payroll register
- Payroll journal and summary showing:
 - (1) monthly and quarterly totals
 - (2) separate totals by type of work
 - (3) separate overtime records
 - (4) check register
 - (5) quarterly reports: 941 (federal), ESC (state)
 - (6) W2s and W3s, 1099s and 1096s
- Also necessary for payroll are individual earning records showing:
 - (1) type of work performed
 - (2) gross payroll by month and quarter
 - (3) overtime by month and quarter.

Basis of premium is the entire remuneration, cash or non-cash. This can include overtime, bonuses, vacation pay, commissions, and sick pay. Exceptions to remuneration include the premium portion of overtime, tips, severance pay, and payment to group insurance or pension plans.

To view audit information en español, go to www.buildersmutual.com/audit.

RISK MANAGEMENT

When you define, identify, analyze and plan for the risks associated with your company's operations, you are protecting your bottom line. That's risk management. Builders Mutual has an entire risk management department dedicated to helping you do just that.

Our risk management team focuses on safety, injury prevention and other business-related losses. We have adopted a proactive approach to controlling losses through education and empowerment.

Resources

Visit the Builders Mutual Risk Management micro-site and find numerous resources to help you develop your own safety program. Navigate to www.buildersmutual.com/RM; all the tools you need are right at your fingertips. Resources include:

- Selection of Tool Box talks to use during safety meetings.
- Sample safety policy to use as a baseline and customize to meet your needs.
- Selection of sample safety program modules to customize.
- Details on BMIC's Fall Protection Program and educational opportunities.
- Safety STUFF – Builders Mutual's online ordering site allows you to purchase necessary safety equipment at discounted prices.

Spanish Website

Builders Mutual offers online risk management resources in Spanish and created a Spanish-only Risk Management micro-site. Tool box talks, the safety policy and safety program modules, Fall Protection Certification Program requirements and more are at your fingertips and are designed to be used by Spanish-speaking policyholders or Spanish-speaking employees. Additionally, you can request a job site safety consultation from a Spanish-speaking Risk Management consultant.

Builders University

Builders Mutual created Builders University (BU) as the industry's center for educational excellence, to assist policyholders in being proactive about safety and risk management.

Our BU instructors help your business strengthen its safety program and address risks that eat away at profits. We provide the tools necessary to develop a comprehensive, high-impact risk management strategy for your business.

Courses offered include:

- Fall Protection (4 hours)
- Enterprise Risk Management for Contractors (3 hours)
- Safety Pays: A Practical Approach to Safety on Your Jobsite (4 hours)
- OSHA 10-Hour Construction Industry Safety Course (10 hours usually broken into two days)
- OSHA 30-Hour Construction Industry Safety Course (30 hours usually broken into five days)
- Defensive Driving Course (4 hours)
- Safety Talks (2 hours)

For complete course descriptions, details and a list of upcoming courses, go to buildersmutual.com/bu.

CLAIMS

Our claims department is known for providing exceptional customer service. Once a claim is filed, one adjuster is assigned to the account as the single point of contact. That adjuster handles the claim from beginning to end through the entire claims experience. The BMIC claims department is thorough and detailed to ensure you, your employees and your business are taken care of from the time the claim is reported to the time it is closed.

Reporting Claims

By Phone: Call our Claims Center at **(800) 809-4862**

By Email: wcnnoticeofloss@bmico.com for Workers' Comp claims
otcnnoticeofloss@bmico.com for all other claims

Online: Login to Builders Online Business and select **Submit a Claim**

Drug testing

BMIC maintains a policy requiring post-injury drug and alcohol testing arising out of any alleged work-related accident. In order to receive workers' compensation coverage, **BMIC expects each employer to notify its employees of this Policy in order that they may be potentially eligible to receive workers' compensation benefits.**

Enclosed is a Notice of this Policy and an Acknowledgment Form which should be made available to all employees. In the event of an alleged on-the-job injury arising out of an alleged work-related accident, the employee will be tested at the time medical treatment is first administered. Pursuant to our policy, BMIC shall pay the cost of this Drug and Alcohol Test as a reasonable expense incurred at BMIC's request.

If the provider refuses to administer a drug and alcohol test, contact the Claims department at (800) 809-4861 while the injured person is at the medical facility. This will enable the Claims department to contact the medical provider to make arrangements to have a drug and alcohol test administered.

FORMS AND THEIR PURPOSE

The following information includes an outline of forms that are necessary to administer or change a policyholder's coverage.

Notice of Election or Rejection of Workers' Compensation Coverage (WCADC4 3.09) - According to the District of Columbia Workers' Compensation Act sole proprietors and partners are excluded from coverage. Should a sole proprietor or partner wish to be included for coverage they should complete this form. Please note that Executive Officers and LLC members must be included for coverage and cannot elect to exclude themselves.

Claims Forms:

Employee's Notice of Accidental Injury or Occupational Disease (OWC-7)

Employee's Claim Application (OWC-7A)

Employer's First Report of Injury or Occupational Disease (OWC-8)

Other Forms:

Drug Policy

Drug Testing Acknowledgement

Workers' Compensation Experience Rating for Non-Affiliate Data (Form ERM-6)

Catastrophe (Other Than Certified Acts of Terrorism) Premium Endorsement

Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement

Notice Of Election of Coverage Under Workers' Compensation Law

New Business Premium Allocation

**NOTICE OF ELECTION OF COVERAGE
UNDER WORKERS' COMPENSATION LAW**

TO: Builders Mutual Insurance Company

RE: _____
(Print Name of Owners or Partners)

doing business as _____
(Firm or Trade Name)

(Address) (City) (State) (Zip)

FEIN: _____

I/we, the sole proprietor or partner of the above named business, do hereby certify that I/we devote full time to the proprietorship or partnership that I/we hereby elect to be included in the definition of employee for the purpose of entitlement to benefits under the Workers' Compensation coverage issued to this company.

Name of Owners or Partners

(Type or Print each officer's name and title under signature)

Date

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

THE COVERAGE SHALL BE EFFECTIVE THIRTY DAYS AFTER RECEIPT.

Return completed form to:

**Underwriting Department
Builders Mutual Insurance Company
Post Office Box 150005
Raleigh, NC 27624-0005**

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKER'S COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011

(202) 576-6265

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. Penalties 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.

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

**EMPLOYEE'S
NOTICE OF ACCIDENTAL INJURY OR OCCUPATION DISEASE**

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYEE

YOU MUST FILE THIS REPORT WITHIN 30 DAYS AFTER YOU BECOME AWARE OF AN ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE AND ITS RELATIONSHIP TO YOUR JOB. PART 1 SHOULD BE MAILED TO THE D.C. GOVERNMENT, OFFICE OF WORKERS' COMPENSATION AT THE ABOVE ADDRESS. PART 2 SHOULD BE MAILED OR DELIVERED TO YOUR EMPLOYER, AND PART 3 RETAINED FOR YOUR RECORDS. IN ORDER TO PRESERVE YOUR RIGHTS UNDER THE LAW, YOU MUST FILE A CLAIM FORM NO. 7a DCWC, A COPY OF WHICH CAN BE OBTAINED FROM YOUR EMPLOYER OR THE OFFICE OF WORKERS' COMPENSATION.

Date and Time of Injury: _____ am/pm?

Place where injury occurred: _____

Description of Injury: _____

THIS IS TO NOTIFY YOU _____
(Employer)

THAT I _____ while in your
employment, sustained an injury ☐ or contracted an occupational disease ☐ as described above, caused by:

Treating Physician's Name and Address: _____

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKER'S COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011

(202) 671-1000

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. Penalties 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.

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

EMPLOYEE'S CLAIM APPLICATION

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYEE

A CLAIM FOR WORKERS' COMPENSATION BENEFITS HAS BEEN FILED WITH THIS OFFICE. YOU HAVE 14 DAYS FROM THE RECEIPT OF THIS NOTICE IF YOU HAVE NO PREVIOUS KNOWLEDGE OF INJURY OR ITS RELATIONSHIP TO EMPLOYMENT, TO BEGIN VOLUNTARY PAYMENTS OF WORKERS' COMPENSATION BENEFITS TO THE ABOVE NAMED EMPLOYEE, OR YOU MUST FILE A NOTICE OF CONTROVERSION, MEMO OF DENIAL OF BENEFITS, FORM NO. 11 DCWC WITH THIS OFFICE. FAILURE TO PAY BENEFITS, UNLESS YOU CONTROVERT THE EMPLOYEE'S RIGHT TO BENEFITS, WILL SUBJECT YOU TO PENALTIES UNDER THE ACT. YOU SHOULD CONTACT YOUR INSURER IMMEDIATELY.

Date and Time of Injury: _____ am/pm? Office Representative _____

Place where injury occurred: _____

Description of Injury: _____

THIS IS TO NOTIFY YOU _____

That while in the employ of the above named employer I sustained a disabling injury ☐ or contracted an occupational disease ☐ as described above. The disability was caused by: _____

Treating Physician's Name and Address: _____

YOU SHOULD HAVE ALREADY FILED OR SHOULD
FILE EMPLOYEE'S NOTICE OF ACCIDENTAL INJURY
OR OCCUPATIONAL DISEASE, FORM NO. 7 DCWC.

I HAVE FILED THE CLAIM WITH THE OFFICE OF
WORKERS' COMPENSATION.

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKER'S COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011

(202) 671-1000

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. Penalties 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.

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

IMPORTANT: Every employer shall file this report as soon as possible after knowledge of an occupational injury or disease to one of his employees, but no later than ten days thereafter. Failure to file this form shall be subject to a civil penalty not to exceed \$1000.

Date and Time of Injury: _____ am/pm? Day of Week?

Normal starting time _____ am / pm? If employee back to work, give date and time _____ am / pm?

At what wage? _____ If fatal, give date of death (file supplement report). _____

Date disability began? _____ am / pm? Was injured paid in full for this day? _____. Was injured given Form No. 7 DCWC?

Foreman

When did you or foreman first know of injury? _____ Male _____ Female _____ Age _____

Employee's telephone No. _____ Occupation when injured _____ was this his/her regular occupation? _____ (Dep't. or Branch where regularly employed) _____

Was injured party hired in DC? _____ How long employed by you? _____ Piece or time worker? _____ Hourly wage? _____

Hours worked/day _____ Daily wages _____ Days worked per week _____ Average weekly earnings _____

If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week, or month: _____

Employer's principle business function in DC _____ Employers Tel. No. _____ Insurance Policy No. _____

Location of plant or place where accident occurred: _____ on employer's premises? _____

Describe fully the events which resulted in injury or disease, what the employee was doing when injured and type of injury including parts of body affected:

Names of Witnesses _____

Nature and location of injury (describe fully): _____

Attending Physician and Address (If Hospital Involved--Indicate):

Name of Person Completing Form

Name (Please Print or Type)

Signature

Official Position

NOTICE

Post Accident Drug/Alcohol Policy

Builders Mutual Insurance Company implemented a post accident drug/alcohol testing policy. As a policyholder of Builders Mutual, you are required to comply with this policy. Implementation of a drug and alcohol testing program can help protect your financial interest, your employees and your job sites.

BMIC's Drug/Alcohol Testing Policy will first and foremost prevent individuals with a drug or alcohol dependency from abusing the workers' compensation system and using your dollars to sustain an illegal habit. Individuals with drug and alcohol dependency also pose a threat to fellow employees, supervisors, and the general public as their actions can cause harm to those around them. Lastly, substance abuse can lead to criminal conduct to finance the habit.

A drug and alcohol test will be required after each work-related injury. The test will be performed at the time medical treatment is first administered and the cost of the test will be covered by Builders Mutual as a reasonable claims expense. **If the treating medical facility refuses to administer a drug and alcohol test, contact the Claims department at 1-800-809-4862 while the injured is still at the facility. This will enable the Claims department to contact the provider to make arrangements to have a drug and alcohol test administered.**

If you have any questions regarding this policy, please contact the Claims department at 1-800-809-4861.

BMIC Drug Testing Acknowledgment

I have read and understand the Policy of Builders Mutual Insurance Company that all employees of policyholders shall be tested for drugs or alcohol if the employee is involved in an alleged work-related accident which might give rise to the filing of a workers' compensation claim. I am an employee of a policyholder and I consent and agree to be tested for the use of alcohol, drugs, or illegal, non-prescribed controlled substances in the event of an alleged work-related accident. I understand that if I do not agree to be tested or submit to any procedure to detect the use of alcohol, drugs, or illegal, non-prescribed substances this will be deemed an admission of impairment by such substances and I understand that when applicable by state law, my workers' compensation claim may be denied or benefits reduced. I understand that if the results of the test are positive for drugs or alcohol, my claim for workers' compensation benefits may be denied.

I hereby acknowledge receipt of this Policy concerning drug and alcohol testing.

This ____ day of _____, _____.

Employee Signature

Employee Name (Print)

Policyholder Representative Signature

AVISO
Reglamento de Examen de Drogas y Alcohol

Builders Mutual, su compañía de seguros, implementó una regla que requiere que todos los empleados lesionados en el trabajo se hagan un examen de drogas y alcohol. Como un asegurado por Builders Mutual, usted está obligado a cumplir con esta reglamentación. El programa de examen de drogas y alcohol puede proteger sus intereses financieros, sus empleados, y su lugar de trabajo.

Nuestra política de examen de drogas y alcohol evitará el abuso del sistema de compensación laboral por parte de empleados con dependencia a drogas o alcohol. Las personas con dependencia a drogas y alcohol también pueden perjudicar el bienestar de otros empleados, supervisores, y del público general, además de que sus acciones pueden causar daño a todos los que le rodean. El abuso de sustancias ilegales puede resultar en actos criminales con el propósito de mantener una adicción.

Builders Mutual exigirá un examen de drogas y alcohol después de cada accidente que ocurra en el trabajo. Este examen debe ser hecho en la primera consulta médica sin ningún costo para el empleado. Builders Mutual pagará por el examen.

Si por alguna razón la clínica se niega a hacer el examen, contacte nuestro departamento de reclamos mientras que su empleado todavía está en la facilidad médica. Nosotros tendremos la oportunidad de contactar la clínica directamente y hacer arreglos para que se haga el examen.

Si usted tiene alguna pregunta acerca de esta reglamentación, por favor contactenos al departamento de reclamos al 1-800-809-4861.

Builders Mutual Insurance Company
Reconocimiento del examen de drogas y alcohol

He leído la política del examen de drogas y alcohol de la compañía de seguros Builders Mutual. Entiendo que todas las personas aseguradas se le harán exámenes de drogas y alcohol si tienen un accidente en el trabajo y que potencialmente resultaría en un reclamo bajo la póliza de compensación laboral. Soy un empleado bajo esta póliza y doy consentimiento/autorización para que me hagan pruebas de drogas y alcohol en caso de un reclamo de accidente bajo esta póliza. Entiendo que si me niego a tomar el examen para detectar estas sustancias, automáticamente, estaría admitiendo que he consumido drogas o alcohol. De acuerdo con la ley de este estado, esto podría resultar en el rechazo o la reducción de los beneficios del reclamo. También, entiendo que si los resultados de estas pruebas son positivos, el reclamo podría ser anulado.

Confirmando que he recibido esta información acerca del reglamento de exámenes de drogas y alcohol.

En este día _____ de _____ del 20____.

Firma del empleado

Nombre de empleado

Firma del asegurado