



YOUR WORKERS' COMPENSATION POLICY GUIDE Georgia

Builders Mutual provides insurance coverage exclusively to the construction industry. It's not just our specialty—it's all we do. Headquartered in North Carolina, our market now includes the Mid-Atlantic and Southeast. We have a history with the North Carolina Home Builders Association, and maintain strong partnerships with various industry associations. From the groundbreaking to the ribbon cutting, we are by your side, helping you avoid risks and enjoy a job well done.

Whether you're dealing with your risk management consultant, auditor or claims adjuster, trust that you have the industry experts at work with you.

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)
- 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

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. Login, enter your payroll and the system will calculate the amount due. You must make an online payment to complete the process.
- Paper worksheets can be mailed to Builders Mutual, 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 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

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

Phone: Pay with credit/debit card, or electronic check. Call our **Customer Contact Center at (800) 809-4859**, Monday-Friday, 8am to 6pm EST.

Online: Pay with a credit/debit card, or electronic check. Go online to pay your bill:
buildersmutual.com/policyholders

Auto-draft: Go online to register individual policies for an automated recurring payment option. Premium will be drafted directly from your checking account.

Go Paperless

Go online to select Go Paperless and receive your policy documents via email.

Returned Checks or Electronic Payments

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

Renewals

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

Cancellation

Should a policyholder request the cancellation of its workers' compensation policy prior to the 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 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 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 representative to conduct a physical onsite audit of your financial records or you may be requested to submit information online to determine the "final" premium. Completing the audit helps to ensure you are paying the right price for your Builders Mutual insurance coverage.

**The completion of an annual audit is required as a condition of your workers' compensation policy. Failure to comply with the annual audit process will result in Builders Mutual estimating your annual premium and applying an audit noncompliance penalty of up to two times the estimated annual premium. This may also result in the cancellation of your workers' compensation policy.*

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 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.

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. As part of our services, we may contact you for a complimentary onsite visit by one of our experienced consultants. Thank you in advance for your assistance in scheduling this at a mutually agreeable time.

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 Risk Management section of our website and find numerous resources to help you develop your own safety program. Navigate to 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 our Fall Protection Program and educational opportunities.
- WorkSafe 101 – “Know the Basics” New Employee Safety Orientation
- Safety products – Builders Mutual's online ordering site allows you to purchase safety equipment at discounted prices.

Spanish Resources

Builders Mutual offers product, risk management and audit resources online in Spanish. Risk Management 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 jobsite safety consultation from a Spanish-speaking Risk Management consultant. To view audit information in Spanish, go to buildersmutual.com/audit.

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

Accidents happen, and when they do, you can rely on our claims department to respond with unparalleled service, speed, and individual attention. Policyholders are assigned a single point of contact who handles your claim from beginning to end. We will thoroughly review your workers' medical bills and case documents, strive to get your vehicles back on the road and equipment back in working order, and protect your interests in costly litigation.

Reporting Claims

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

By Email: noticeofloss@bmico.com

Online: Login and select **Submit a Claim**

Drug testing

Builders Mutual 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, **Builders Mutual 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, Builders Mutual shall pay the cost of this Drug and Alcohol Test as a reasonable expense incurred at our 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 (WC 10) - This form is required if a corporate officer or limited liability company member elects to reject coverage; if a sole proprietor or partner elects to be included as an employee; or if a farm labor employer elects to provide coverage for farm laborers.

Confidential Request for Information (Form #ERM-14) - This form is used for any change to the structure or nature of the business including but not limited to: combination of separate entities, change of ownership, merger or consolidation. Policyholders should also submit an additional Entity/Location Inclusion form (Form #WCA-6).

Claim Forms:

Workers' Compensation Notice and Instructions to Employers and Employees (WC-P1)

Employer's First Report of Injury or Occupational Disease (WC-1)

Wage Statement (WC-6)

Notice of Payment/Suspension of Benefits (WC-2)

Notice to Employee of Medical Release to Return to Work with Restrictions or Limitations (WC-104)

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF ELECTION OR REJECTION OF WORKERS' COMPENSATION COVERAGE

The use of this form is required under the provisions of: (A) O.C.G.A. §34-9-2.1 of the Workers' Compensation Law if a corporate officer or limited liability company member elects to reject coverage; (B) O.C.G.A. §34-9-2.2 if a sole proprietor or partner elects to be included as an employee; or, (C) O.C.G.A. §34-9-2.3 if a farm labor employer elects to provide coverage for farm laborers.

A. CORPORATION / LIMITED LIABILITY COMPANY	
I, _____, certify that I am a member of _____	(Employer)
(Type or Print Name)	
_____	_____
(Office Held)	(Street Address)
<input type="checkbox"/> I elect to reject the provisions of the Georgia Workers' Compensation Law.	_____
	(City / State / Zip Code)
<input type="checkbox"/> I elect to revoke the previous rejection of _____	_____
	(Date)
(NOTE: A maximum of five (5) officers / members may be exempted)	

B. SOLE PROPRIETOR OR PARTNER	
I, _____, certify that I am a	<input type="checkbox"/> Sole Proprietor of _____
	(Business Name)
	<input type="checkbox"/> Partner
<input type="checkbox"/> I elect to be covered under the provisions of the Georgia Workers' Compensation Law.	
<input type="checkbox"/> I elect to revoke the previous election of _____	_____
	(Date)

C. FARM LABOR	
I, _____, certify that as the employer or representative of _____, that	_____
	(Business Name)
<input type="checkbox"/> I elect to provide Workers' Compensation coverage for farm laborers.	
<input type="checkbox"/> I elect to revoke the previous election of _____	_____
	(Date)

D. CERTIFICATION		
<input type="checkbox"/> I hereby certify that the information listed is true and correct		
Print Name	Business Phone Number and Ext.	Signature
Business Address		
Dated this _____ Day of _____ / _____		
(Month) (Year)		
A COPY OF THIS FORM MUST BE FILED WITH YOUR CURRENT WORKERS' COMPENSATION CARRIER. IF YOU DO NOT HAVE A CARRIER, THIS FORM MUST BE FILED WITH THE STATE BOARD OF WORKERS' COMPENSATION AT 270 PEACHTREE STREET, N.W., ATLANTA, GEORGIA 30303-1299. NOTE: DO <u>NOT</u> SEND TO THE BOARD IF THERE IS INSURANCE COVERAGE.		

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.sbwcc.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).

(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 Workers' Compensation Law.

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

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 workers' 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>

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

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

Name

address

phone

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).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Phone Number	Employee E-mail
Address		City	State	Zip Code
EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg., etc.)	
Address		Phone Number	Employer FEIN	
City		State	Zip Code	Employer E-mail
INSURER / SELF-INSURER	Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #	
CLAIMS OFFICE	Name	Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
SBWC ID# (five digit no.)	Address	City	State	Zip Code
EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: <input type="checkbox"/> per Hour <input type="checkbox"/> per Day <input type="checkbox"/> per Week <input type="checkbox"/> per Month
Insurer Type Code <input type="checkbox"/> I - Insurer <input type="checkbox"/> S-Self-insurer <input type="checkbox"/> G-Guarantee Fund		List Normally Scheduled Days Off		
INJURY/ILLNESS & MEDICAL	Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm	County of Injury	Date Employer had knowledge of Initial Disability	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Injury/Illness Occur on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				
Treating Physician (Name and Address)		Initial Treatment Given: <input type="checkbox"/> None <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinical/Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: Returned at what wage _____ per Week If Fatal, Enter Complete Date of Death
Report Prepared By (Print or Type)			Telephone Number	Date of Report

B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only <input type="checkbox"/> Yes <input type="checkbox"/> No	Average Weekly Wage: \$ _____ Weekly benefit: \$ _____	Date of disability: _____
Date of first Payment: _____ Compensation paid: \$ _____ or Date salary paid: _____ Penalty paid: \$ _____		
BENEFITS ARE PAYABLE FROM _____ FOR:		
<input type="checkbox"/> Temporary total disability <input type="checkbox"/> Temporary partial disability <input type="checkbox"/> Permanent partial disability of _____ % to _____ for _____ weeks.		
UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.		

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

D. MEDICAL ONLY INJURY No disability paid or controverted

(Insurer / Self-Insurer: Type or Print Name of Person Filling Form)	Signature	Date
Phone and Ext.	E-mail	

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.sbcw.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).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.
2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.** Do not send this form to the State Board of Workers' Compensation.
3. If you need additional help, call your insurance company or self-insurer claims office.
4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682

In Atlanta: (404) 656-3818

<http://www.sbwc.georgia.gov>

GEORGIA STATE BOARD OF WORKERS' COMPENSATION WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address			
E-mail Address		City	State	Zip Code	
EMPLOYER	Name	Address			
E-mail Address		City	State	Zip Code	
INSURER/ SELF-INSURER	Name		Address		
CLAIMS OFFICE	Name	SBWC ID# (five digit number)			
E-mail Address		Insurer/Self-Insurer File #	City	State	Zip Code

B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment.

13 Weeks of Employee's Wages
 13 Weeks of a Similar Employee's Wages
 Full time weekly wage of injured employees
 Wage at date of injury per week: _____

SCHEDULE OF WEEKLY EARNINGS

Week	From Date MM/DD/YYYY	To Date MM/DD/YYYY	No. of Days Worked	Gross Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
					Meals	Lodging	Rent	Tips	Other	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
Total										
Average Weekly Earnings										

C.	REMARKS:
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Type or Print Name	Signature	Date
E-mail Address	Phone Number	

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).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

INITIAL PAYMENT RE-COMMENCE SUSPEND AMENDMENT: WC-1 Dated _____
 WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	Employee E-mail	EMPLOYER	Name
Address		Address	
City		State	Zip Code
City	State	Zip Code	Employer E-mail
INSURER/ SELF-INSURER	Name	Address	
CLAIMS OFFICE	Name	City	State Zip Code
Insurer/Self-Insurer File #	Claims Office E-mail	Phone Number	SBWC ID# (five digit no.)

B. INCOME BENEFITS

Benefits are being paid to this employee at the rate of \$ _____ *per week based on an average weekly wage of \$ _____ payable from ____ / ____ / ____ for:

Temporary Total Disability
 Temporary Partial Disability
 Permanent Partial Disability of ____ % to ____ to be paid for ____ weeks (**medical report attached**).
(Part of Body)

Date of Disability _____

The date of the first check is, ____ / ____ / _____, the amount is \$ _____, or date salary was paid ____ / ____ / ____ and this:

Does not include a penalty
 Does include a ____ % penalty in the amount of \$ _____.

**File Form WC-6, Wage Statement, if weekly benefit is less than maximum.*

C. SUSPENSION OF BENEFITS

Benefits will be suspended on ____ / ____ / ____ because:

1.) Employee returned to work on ____ / ____ / ____ without restrictions from the authorized treating physician.

2.) Employee returned to work on ____ / ____ / ____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

3.) Employee returned to work on ____ / ____ / ____ with restrictions from the authorized treating physician at reduced pay of \$ _____ per week and temporary partial disability benefits are shown in Part B above.

4.) Employee was able to return to work on ____ / ____ / ____ without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached (Board Rule 221).

5.) The employee had undergone a change in condition pursuant to O.C.G.A. § 34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release. Temporary partial disability benefits are shown above in part B above. **A copy of the Form WC-104 is attached.**

6.) The employee has been offered suitable employment pursuant to O.C.G.A. § 34-9-240 and has unjustifiably refused to attempt to perform the job. Form WC-240 was sent at least ten days before the employee was required to report for work. **A copy of the Form WC-240 is attached.**

7.) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid.

8.) The entire permanent partial disability benefit has been paid.

9.) The maximum of temporary partial disability payments has been paid.

10.) This claim is being controverted within sixty days of the due date of first payment. **A copy of the Form WC-3 is attached and a copy was sent to the employee.**

11.) Other:

Insurer/Self-Insurer Type or Print Name	Signature	Date
Phone Number and ext.	E-mail	

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record

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.sbcw.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).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. OUTLINE OF BENEFITS OTHER THAN MEDICAL EXPENSE

In addition to paying your medical expenses for an injury at work, the employer will pay you for part of your lost wages if you are disabled from work for more than seven (7) calendar days because of your work-related injury.

TEMPORARY TOTAL

O.C.G.A. §34-9-261: IF YOU ARE NOT ABLE TO WORK AT ALL because of your injury, your employer/insurer must pay:

- 2/3 of your average weekly wage with a maximum of \$450 per week if your date of accident was on or after July 1, 2005, and a maximum of \$500 per week if your date of accident was on or after July 1, 2007.
- A minimum of \$50.00 per week, or your actual weekly wage if less than \$50.00 per week. If your accident occurred on or after July 1, 1992, and if your injury is not catastrophic, you are not entitled to this type of benefit for more than 400 weeks. Furthermore, your benefits may be reduced to those allowed by O.C.G.A. §34-9-262 under certain circumstances after you have been released to return to work with limitations or restrictions.

TEMPORARY PARTIAL

O.C.G.A. §34-9-262: IF YOU MUST WORK FOR LOWER WAGES because of your injury at work, your employer/insurer will pay:

- 2/3 of your wage loss (the difference between what you make after your injury and what you made before), with a maximum of \$300 per week if your date of accident was on or after July 1, 2005, and a maximum of \$334 per week if your date of accident was on or after July 1, 2007 for a maximum of 350 weeks from the date of accident.

PERMANENT PARTIAL

O.C.G.A. §34-9-263: IF YOU LOST A PART OR MEMBER OF YOUR BODY or lose the use of a member (such as arm, finger, eye, etc.), you will first receive benefits described above during disability, and then upon return to work or otherwise becoming ineligible for TTD or TPD benefits, you will receive payment for permanent partial disability for a certain number of weeks, based on the percentage of your loss. Multiply the permanent partial disability (%) by the maximum number of weeks listed below to determine the number of weeks you will receive PPD benefits. For example, for a 15% permanent partial disability to an arm, multiply 15% times 225 weeks. The answer of 33.75 represents the number of weeks you will receive income benefits.

<u>Bodily Loss</u>	<u>Maximum Weeks</u>
Arm	225
Leg	225
Hand	160
Foot	135
Thumb	60
Index Finger	40
Middle Finger	35
Ring Finger	30
Little Finger	25
Great Toe	30
Any toe other than great toe	20
Loss of hearing, traumatic	
One ear	75
Both ears	150
Loss of vision of one eye	150
Disability to the body as a whole	300

In all cases arising under the Workers' Compensation Law, any percentage of disability or bodily loss ratings shall be based upon Guides to the Evaluation of Permanent Impairment, Fifth Edition, published by the American Medical Association.

O.C.G.A. §34-9-220: The employer is not required to pay benefits for the first seven (7) calendar days you miss work because of your injury, unless you miss 21 consecutive days because of your injury.

O.C.G.A. §34-9-221: If income benefits are paid late, the employer/insurer will pay you a 15% penalty on all accrued benefits. If benefits are paid late after an award has been issued, the employer/insurer will pay you a 20% penalty.

B. RIGHT TO HEARING

If your benefits have been suspended and you believe that benefits were suspended incorrectly, you should request a hearing by sending Form WC-14 to the State Board of Workers' Compensation at the address below. If you need a Form WC-14, please contact the State Board of Workers' Compensation at the phone numbers listed below or visit the website.

STATE BOARD OF WORKERS' COMPENSATION
 270 PEACHTREE STREET, N.W.,
 ATLANTA, GEORGIA 30303-1299
 In Atlanta: 404-656-3818
 or: 1-800-533-0682
<http://www.sbwc.georgia.gov>

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).

WC-104 NOTICE TO EMPLOYEE OF MEDICAL RELEASE TO RETURN TO WORK WITH RESTRICTIONS OR LIMITATIONS
GEORGIA STATE BOARD OF WORKERS' COMPENSATION
NOTICE TO EMPLOYEE OF MEDICAL RELEASE TO RETURN TO WORK
WITH RESTRICTIONS OR LIMITATIONS

Instructions: The employer shall use this form to notify an employee that the authorized treating physician has released the employee to return to work with restrictions or limitations, as required by O.C.G.A. §34-9-104(a). This form, with attached medical report, must be sent to the employee and counsel for the employee, within 60 days of the release to return to work. File the Form WC-2 and attach the Form WC-104 only when converting from TTP to TPD and attach a medical report.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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A. IDENTIFYING INFORMATION					
EMPLOYEE	County of Injury			INSURER/ SELF-INSURER	Name
	Address			CLAIMS OFFICE	Name
City		State	Zip Code	Address	
E-mail			City		
		State	Zip Code		
EMPLOYER	Name				
	Address				
City		State	Zip Code	SBWC ID# (five digit no.)	Insurer/Self-Insurer File #
E-mail			Phone Number		
			E-mail		

B. NOTICE TO EMPLOYEE	
1. Your injury, which occurred on or after July 1, 1992, is not catastrophic, as defined in O.C.G.A. §34-9-200.1(g). 2. You are receiving income benefits, and are not working. 3. Your authorized treating physician, who is _____ has released you to work with restrictions or limitations on _____ 4. The limitations from the physician are as follows: _____	
A copy of the physician's report, which authorizes your release and describes your limitations, is attached.	
5. Because you have been released to return to work with restrictions, your income benefits will be reduced from \$ _____ per week to \$ _____ per week on _____, unless you return to work at an earlier date.	

<input type="checkbox"/> I certify that I have today sent a copy of this form with the attached medical report to the employee and counsel for the employee, if represented.		
Print Name	Date	Signature
Phone Number	Employer / Insurer	
E-mail		

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.sbcw.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).

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.

After each work related injury, a drug and alcohol test should be performed on the injured employee and all other employees whose conduct could have contributed to the accident if there is a reasonable possibility that drug and/or alcohol use by the injured employee and/or co-employees could have contributed to the injury or illness. 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.

Después de cada lesión relacionada con el trabajo, se debe realizar un examen de drogas y/o alcohol al empleado lesionado y a todos los empleados cuyo comportamiento pudo haber afectado el accidente, si existe la posibilidad del uso de drogas y/o alcohol por parte del empleado lesionado y/o los colaboradores pudo haber contribuido a la lesión o enfermedad. 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