Builders Mutual®
INSURANCE COMPANY
Where Builders Come First®

YOUR WORKERS' COMPENSATION POLICY GUIDE
Georgia

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.

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 adjustor is assigned to the account as the single point of contact. That adjustor 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: wcnoticeofloss@bmico.com for Workers' Comp claims
otcnoticeofloss@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 (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 _____
(Type or Print Name) (Employer)

_____ _____
(Office Held) (Street Address)

_____
(City / State / Zip Code)

❑ I elect to reject the provisions of the Georgia Workers' Compensation Law.

❑ 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 ❑ Sole Proprietor ❑ Partner of _____
(Business Name)

❑ I elect to be covered under the provisions of the Georgia Workers' Compensation Law.

❑ I elect to revoke the previous election of _____
(Date)

C. FARM LABOR

I, _____, certify that as the employer or representative of _____, that
(Business Name)

❑ I elect to provide Workers' Compensation coverage for farm laborers.

❑ I elect to revoke the previous election of _____
(Date)

D. CERTIFICATION

❑ 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 NOT 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.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).

(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).

WC-P1 (7/2006)

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

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

A. IDENTIFYING INFORMATION

EMPLOYEE	❑ Male ❑ 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: ❑ per Hour ❑ per Day ❑ per Week ❑ per Month
Insurer Type Code ❑ I – Insurer ❑ S-Self-insurer ❑ G-Guarantee Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ❑ am ❑ 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? ❑ Yes ❑ No	Did Injury/Illness Occur on Employer's premises? ❑ Yes ❑ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address)	Initial Treatment Given: ❑ None ❑ Minor: By Employer ❑ Minor: Clinical/Hospital ❑ Emergency Room ❑ 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 ❑ Yes ❑ 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:

❑ Temporary total disability ❑ Temporary partial disability ❑ 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.sbwc.georgia.gov

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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

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:

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

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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

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 _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

❑ 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.sbwc.georgia.gov

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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.

Bodily Loss	Maximum Weeks
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).

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

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	SBWC ID# (five digit no.)	Insurer/Self-Insurer File #
Address			
City	State / Zip Code	Phone Number	
E-mail		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.

❑ 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.sbwc.georgia.gov

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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.

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 examenes 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, automaticamente, 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.

Confirmo que he recibido esta información acerca del reglamento de examenes de drogas y alcohol.

En este dia _____ de _____del 20___.

_____
Firma del empleado

_____
Nombre de empleado

_____
Firma del asegurado

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 interéses 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 exijirá 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 razon la clínica se niega a hacer el examen, contacte nuestro departamento de reclamos mientras que su empleado todavia está en la facilidad médica. Nosotros tendrémos 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.

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