

YOUR WORKERS' COMPENSATION POLICY GUIDE Maryland

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 as the industry's center for educational excellence, to assist policyholders in being proactive about safety and risk management.

Our 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:

- WorkSafe 101 (1 hour)
- 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 four days)
- Defensive Driving Course (4 hours)
- Safety Talks (customized to meet your needs.)

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.

Inclusion Form (C-15-R 11/2002) Sole Proprietors/Partnerships - Use this form to include Sole Proprietors and Partnerships in Workers' Compensation Coverage.

Exclusion Form (C-16R 11/2002) - Officers or Members of Farm Corporations, Close Corporations, Professional Corporations or Limited Liability Company's meeting the requirements contained in Labor and Employment Article §9-206. Use this form if you desire to exclude these parties from Workers' Compensation coverage.

Workers' Compensation in Maryland (MC WCC Form C-24) – This notice **must be printed** on 8.5" by 14" gold or yellow paper, display complete employer information and be posted in a conspicuous location at each work site or location in accordance with COMAR 14.09.01.02 and 14.09.01.03.

Claims Forms: Employer's Instructions (1A-1) Employer's First Report of Injury or Occupational Disease (1A-1) Statement of Wage Information (C-2) Insurer's Termination of Temporary Total Disability Benefits (C-06)

Other Forms: Drug Policy Drug Testing Memo 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 New Business Premium Allocation Conspicuous Minor Notice

10 East Baltimore Street Baltimore, Maryland 21202-1641

TEL: (410) 864-5100 or 1(800) 492-0479 TTD (MD Relay Service) : 1(800) 735-2258 http://www.wcc.state.md.us

Date Stamp – WCC Use Only

INCLUSION FORM

SOLE PROPRIETORS/ PARTNERS ELECTION FORM

Pursuant to the provisions of Title 9, § 9-219 and § 9-227 of the Annotated Code of Maryland, sole proprietors and partners are excluded from coverage under the Workers' Compensation Act of Maryland. Such persons may elect to become covered employees under the Workers' Compensation Act of Maryland.

To exercise this option, any sole proprietor or partner wishing to be a covered employee must sign this document.

IMPORTANT:

Submit original form to the Workers' Compensation Commission, a copy to the insurer, and keep a copy for your files.

Unless otherwise agreed upon, this election will be effective upon the date of receipt by the Workers' Compensation Commission.

CURRENT DATE: _____ DATE INSURANCE COMPANY WAS NOTIFIED: _____

NAME OF INSURANCE COMPANY: Builders Mutual Insurance Company

ADDRESS: _____

CITY: ______ STATE: _____ ZIP: _____

Name and Title of Person Electing Coverage	Social Security Number	Personal Signature

10 East Baltimore Street Baltimore, Maryland 21202-1641 TEL: (410) 864-5100 or 1 (800) 492-0479 TTD (MD Relay Service): 1(800)735-2258 http://www.wcc.state.md.us

Date Stamp	-	WCC	Use	Only
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EXCLUSION FORM

Pursuant to the provisions of Labor & Employment Article § 9-206 of the Annotated Code of Maryland, officers or members of a Farm Corporation, Close Corporation, Professional Corporation, or Limited Liability Company are covered employees if the officer or member provides a service for monetary compensation. Such officers or members who satisfy the criteria of Labor & Employment Article § 9-206(b) may elect to become excluded from coverage by filing this Exclusion Form with the Commission.

To exercise this option, any officer or member from the aforementioned types of organizations wishing to be excluded must sign this document. **NOTE: By signing this Exclusion Form below, each officer or member affirms under the penalties of perjury that the information contained in this form is true and correct as to that officer or member, to the best of the officer's or member's knowledge, information, and belief.**

DATE: DATE COMPANY NOTIFIED INSURANCE COMPANY:			
NAME OF CORPORATION'S INSURANC	E COMPANY:		
NAME OF COMPANY:			
Type of Company (Choose) Farm Corporation	Close Corporation	Professional Corporation	Limited Liability Company
ADDRESS:			
CITY:	STATE:	Z	IP:
Typed Name and Title of the or Member Electing Exclu		% of Ownership	Personal Signature

IMPORTANT: Submit *original* form to the Workers' Compensation Commission, a copy to the insurer of the company/corporation, and keep a copy for your files.

FORM C-16R (11/2002)

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS UNLESS APPROPRIATE

DATES:

Enter all dates in MM/DD/YY format. Enter all time in HH:MM format (e.g. 06:05)

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status.		The valid choices are:	
Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS - cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED: Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM OSHA LOG REPORT PURPOSE
Name	
Address	
City State MD	
Zīp -	
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) LOCATION #
	PHONE #
	CityState MD () -
CARRIER (NAME, ADDRESS, & PHONE #) Name	POLICY PERIOD CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Address	TO Address
City State MD	// City State MD
Zīp - Phone () -	Zip - Phone () -
CARRIER FEIN	
POLICY/SELF-INSURED NUMBER	SELF INSURANCE
EMPLOYEE Last Name Middle	DATE OF BIRTH SOCIAL SECURITY DATE HIRED STATE OF HIRE
First Name	// MD
Address	SEX MARITAL STATUS OCCUPATION JOB TITLE
City	Male Unmarried Single/Divorced EMPLOYMENT STATUS
State Will	O Female O Married Full-Time
	O Unknown O Separated NCCI CLASS CODE
# OF DEPENDENTS	Unknown
RATE PER: Day Week Mont	D Other # DAYS WORKED/WEEK 5 FULL PAY FOR DAY OF INJURY? Yes No
TIME EMPLOYEE BEGAN DATE OF INJURY/ILLNESS TIME OF OCCUF	
: O AM O PM // : O	AM O PM / / / / / / / / / / Unknown / / / / / // / / / /
· · · · · · · · · · · · · · · · · · ·	F INJURY/ILLNESS PART OF BODY AFFECTED
() -	
	TYPE OF INJURY/ILLNESS CODE PART OF BODY AFFECTED CODE
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSUR	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACC	CIDENT OR WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS
ILLNESS EXPOSURE OCCURRED	EXPOSURE OCCURRED
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURE	DESCRIBE THE SEQUENCE OF EVENTS CAUSE OF INJURY CODE
DATE RETURN(ED) TO WORK IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? O Yes O No
	WERE THEY USED? O Yes O No
	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS) INITIAL TREATMENT Name No MEDICAL TREATMENT
Address	Address MINOR BY EMPLOYER
	City State MD - EMERGENCY CARE
WITNESS NAME	PHONE () - HOSPITALIZED > 24 HOURS
ADMINISTRATOR NOTIFIED DATE PREPARED PREPARER'S NAME &	TITLE PHONE () - FUTURE MAJOR MEDICAL/ PHONE NUMBER LOST TIME ANTICIPATED

WCC Web Form I	A-1	
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Statement of Wage Information

The information below is provided pursuant to COMAR 14.09.01.07 and LE, §9-602(a)(2), Annotated Code of Maryland.

This form should be submitted before the consideration date or to provide updated wage information. When a claim has already been filed, a copy of this form shall be sent to the Workers' Compensation Commission and the claimant or his/her attorney.

Injured Employee Name:

Social Security Number:

WCC Claim Number:

Date:

*Was this employee provided free rent, lodging, board, tips or other allowances in addition to the above earnings? If "yes", the weekly or bi-weekly value must be included in the "Other Allowances" Column.

When the employee is paid weekly, complete each row for the most recent 14 weeks where wages were paid. If paid alternate weeks please enter in the clear, even-numbered rows. If paid on any other schedule, please use the worksheet on page 2 to calculate the average weekly wage. If less than 14 weeks were worked by the employee, use the worksheet on page 2.

Week #	Week Ending (MM/DD/YYYY)	Days Worked	Gross Wages including overtime	Other Allowances*	Total Amount Paid
1					0.00
2					0.00
3					0.00
4					0.00
5					0.00
6					0.00
7					0.00
8					0.00
9					0.00
10					0.00
11					0.00
12					0.00
13					0.00
14					0.00
TOTALS		0	0.00	0.00	0.00
TOTAL	0.00	divided by num worked (where w paid/indicated)	ber weeks vages are 14	₌ Average Week Waş	-

CERTIFICATION OF SERVICE -

I hereby certify that on the above date, a copy of this Statement of Wage form was mailed to the Workers' Compensation Commission and the claimant or his/her attorney. **SUBMITTED BY:**

Name		Signature
		Title
Street		
City	State	_ ZIP Code
Telephone	Email	
10 East Baltimore Street · Baltimore, Maryland 21202-1641		

410-864-5100 · Email: info@wcc.state.md.us · Web: http://www.wcc.state.md.us

Statement of Wage Information

CALCULATION OF AVERAGE WEEKLY WAGE WHEN CLAIMANT IS PAID OTHER THAN WEEKLY OR BI-WEEKLY (Monthly, Semi-Monthly or other)

Α.	Inclusive dates used in wage statement	to
В.	Number of days used in calculation (Minimum 98 days to capture 14 weeks)	
C.	Gross wages (including overtime, free rent, lodging, board, tips & other allowances)	
D.	Daily Rate (C ÷ B)	
E.	Average Weekly Wage (D x 7)	
	Average Weekly Wage (E) =	

(Please enter this amount on page 1 as Average Weekly Wage)

INSURER'S TERMINATION OF TEMPORARY TOTAL DISABILITY BENEFITS

Pursuant to LE §9-733(b), Annotated Code of Maryland, this form must be sent to the claimant. A copy must also be sent to the Workers' Compensation Commission and claimant's attorney.

WCC Claim Number Socia Claimant Employer Insurer	
This is your last temporary total disability cor benefits through: (dat	
The insurer/employer has terminated your payment 1. You returned to work on 2. There is no medical evidence or docume 3. You failed to keep the medical appointme 4. You have reached maximum medical imp 5	(date) entation to support continuing payment. ent scheduled for (date) provement.
Contact Insurer Representative for further information if desired. After contacting the insu are dissatisfied, you have the right to request a hearing b Please include a copy of this form with your request for a selecting the appropriate Temporary Total Disability issue	urance representative, if you are in disagreement or before the Workers' Compensation Commission. a hearing on the MD WCC "Issues" form (H24R)
INSURER CERTIFIC I hereby certify that a copy of this form has been Commission and sent to all parties and/or their an Signature	ttorneys.
Name	Date

Telephone Number _

10 East Baltimore Street · Baltimore, Maryland 21202-1641 410-864-5100 · Email: info@wcc.state.md.us · Web: http://www.wcc.state.md.us

IMPORTANT NOTICE FOR EMPLOYERS

Maryland law requires that a work permit is required for every minor employee.

JADOR in Maryland	¿Accidentes por lesión/daño corporal relacionados con el Empleo o Enfermedad Profesional? Si usted se encuentra incapacitado o inhabilitado para trabajar por más de tres días, el seguro de trabajadores que tienen las compañías pudiera cubrir las facturas médicas y otros gastos relacionados. También le comp-	2.13 de sus ingresos (Hasta un monto maximo estipulado por la ley). 51 usted sufre una lesión en el trabajo, debe: 1. Informarle a su empleador o supervisor de inmediato. No podría recibir todos sus beneficios a menos que su empleador fuere notificado que sufrió una lesión. 2. Informarle al médico quien le administre tratamiento que usted se lesionó en su trabajo.	 Llenar el formulario Employee's Claim Form C-1 (disponible consultando la página del Internet para el Workers' Compensation o solicitándo uno por teléfono). Diligenciarlo para que las oficinas del Workers' Compensation lo reciban lo antes posible. 	Aviso: El suministrar información falsa u ocultar información sobre cualquier actividad relacionada con su trabajo o relacionada con su regreso al trabajo, pudiera afectar los beneficios que recibiera o pudiera acarrearle multas, encarcelamiento o ambas.	Maryland Workers' Compensation Commission 10 East Baltimore Street, Baltimore, Maryland 21202-1641 (410) 864-5100 / Outside Baltimore (800) 492-0479 Webpage - http://www.wcc.state.md.us / TTY Users - 711 in Maryland or (800) 735-2258 This notice must be printed on 8.5" X 14" gold or yellow paper, display complete employer information and be posted in a conspicous location at each work site or location in accordance with COMAR 14.09.01.02 and 14.09.01.03.
WORKERS' COMPENSATION LA COMPENSACIÓN DEL TRABAJADOR	Job Related Accidental Personal Injury or Occupational Disease? If you are disabled and unable to work for more than three (3) days, your employer's workers' compensation insurance company may pay your medical bills and other expenses and replace two-thirds (2/3) of your salary (limited to the maximum set by law).	If you are injured on the job:1. Notify your employer or supervisor at once. You cannot receive full benefits unless your employer knows you are injured.2. Tell the doctor who treats you that you were hurt on the job.3. Complete an Employee's Claim Form C-1 (available by phone or on the Commission's website) and send it to us as soon as possible.	Note: Withholding information or giving false information about any work-related activity or return to work could prevent you from receiving benefits and may subject you to fines, imprisonment or both.	Avi Employer/Empleador	Business Address/Dirección City/State/Zip Ciudad/Estado/Código Postal Federal Employer ID (FEIN) Indentificación Federal Del Empleador Telephone Number/Número Telefónico Insurance Company Name Builders Mutual Insurance Company La Compañía de Seguro B88-612-0399 Telefónico de Seguro Balefónico

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 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.

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 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.

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