



**YOUR WORKERS' COMPENSATION POLICY GUIDE
North Carolina**

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

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

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

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

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- Certificate of Exemption from Coverage (Form WCA2)
- Revocation of Certificate of Exemption from Coverage (Form WCA3)
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- Withdrawal of Election of Coverage (Form WCA5)
- Employee Notice (Form 17)
- Employer’s Report of Injury to Employee (Form 19)
- Wage Statement (Form 22)
- Itemized Statement of Charges for Travel (Form 25T)
- Return to Work (Form 28 and 28T)

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

Cancellation of insurance coverage may result because of the following:

- Non-Payment of premium, including NSF returned check, failure to submit monthly self-audit worksheets, failure to submit to or pay year-end audit, failure to pay deposit balance
- Conviction of named insured of a crime which affects hazard that is insured against
- Failure to meet Risk Management or Underwriting requirements and standards
- Change in risk which increases hazard
- Determination that continuation would jeopardize solvency or place insurer in violation of insurance laws
- Violation of policy terms or conditions
- Commissioner's approval
- Material misrepresentation in obtaining the policy, pursuing a claim, or renewing the policy
- Substantial breaches of contractual duties, conditions, or warranties
- Fraudulent acts by the insured or the insured's representatives that materially affect the nature of the risk
- If the insurer loses its reinsurance for the risk

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

Termination - Policyholder's Request

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

- Signature of an Owner or Officer
- Reason for Termination

Termination - Duplicate Coverage

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

PREMIUM AUDIT

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

Variables affecting your audit

Classifications

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

Subcontractors

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

Workers' Compensation

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

Subcontractor waivers are *not* accepted.

Your records

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

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

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

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

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

RISK MANAGEMENT

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

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

Resources

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

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

Spanish Website

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

Builders University

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

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

Courses offered include:

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

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

CLAIMS

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

Reporting Claims

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

By Email: wnoticeofloss@bmico.com for Workers' Comp claims
otcnoticeofloss@bmico.com for all other claims

Online: Log 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.

Certificate of Exemption from Coverage (Form WCA-2) – For corporations only. Its execution and submission to BMIC will exempt corporate officers from coverage under the Workers' Compensation Act. (Note: Under the Workers' Compensation Act, corporate officers are automatically included for coverage unless they file this Certificate of Exemption.)

Revocation of Certificate of Exemption from Coverage (Form WCA-3) - For corporations only. Its execution and submission will allow BMIC to revoke a previously submitted Certificate of Exemption.

Notice of Election of Coverage (Form WCA-4) - For sole proprietors and partnerships only. Its execution and submission will allow BMIC to provide coverage for the sole proprietor and/or partners. (Note: Under the Workers' Compensation Act, sole proprietors and partners are not automatically covered. Coverage may only be obtained by filing this Notice of Election of Coverage.)

Withdrawal of Election of Coverage (Form WCA-5) - For sole proprietors and partnerships only. Its execution and submission will allow BMIC to revoke a previously submitted Notice of Election.

Employee Notice (Form 17) – The North Carolina Workers' Compensation Act requires this notice to be posted in a conspicuous location where *all* employees can see it.

Employer's Report of Injury to Employee (Form 19) – The law requires you as the employer to report an injury within five days of your notification and to provide a copy of the Form 19 to the injured employee. Failure to do so could cause a fine to be levied against you. Proper reporting will aid with prompt payment of claims that are covered. A claims representative will complete the Form 19 if the injury is reported by telephone. Copies of the form will be mailed to the employer and injured employee.

Wage Statement (Form 22) – When reporting an accident that requires the injured to be out of work for more than seven days, a Form 22 needs to be completed at the time the accident is reported.

If the injured employee has been an employee for a year or more, wages and days worked for the year prior to the accident date will be needed to calculate the average weekly wage and compensation rate.

Example:

Date of Injury 5-19-00

The Wage Chart should show "X" on all days worked from 5-21-99 through 5-19-00.

If the injured employee has been employed less than one year, the statement should show "Xs" on *all* days worked and the *gross* earnings for this period of time.

If the injured employee has been employed three months or less, two wage statement forms need to be completed. This is needed to calculate the appropriate compensation rate for the injured employee. The first statement is completed for the injured employee for *all* days worked and *gross* earnings for this time period. The second statement is completed on a similar employee who has been employed as close to a year as possible. This similar employee should be someone making the same rate per hour and who works the same number of hours as the injured employee.

Return to Work (Forms 28 and 28T) – When an injured employee returns to work, please call our office immediately. Complete Return to Work (Form 28) when an employee returns to full duty. Form 28T should be completed is the injured employee returns to work with restrictions, by way of limited hours, at limited duty, or when the employee is not receiving full salary (example: no heavy lifting). Failure to advise us immediately of the return to work date could result in overpayment to the employee.

**CERTIFICATE OF EXEMPTION FROM COVERAGE UNDER
WORKERS' COMPENSATION LAW**

TO: Builders Mutual Insurance Company

RE: _____
(Print Name of Corporation)

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

FEIN: _____ **NCDI #:** _____ **Unit #:** _____

I/we, the undersigned corporate officers of the above named corporation, hereby elect to be exempt from coverage under the North Carolina Workers' Compensation Act.

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

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

EXEMPTION FROM COVERAGE SHALL BE EFFECTIVE THIRTY DAYS AFTER RECEIPT.

Return completed form to:

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

**REVOCATION OF CERTIFICATE OF EXEMPTION FROM COVERAGE
UNDER WORKERS' COMPENSATION LAW**

TO: Builders Mutual Insurance Company

RE: _____
(Print Name of Corporation)

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

FEIN: _____ **NCDI #:** _____ **Unit #:** _____

You are hereby notified that the undersigned hereby waives exemption from the operation and effect of the Workers' Compensation Law, revoking the Certificate of Exemption previously filed, which revocation is specifically provided by Section 97.02(2) of that law, and accepts the terms, conditions and provisions of said Act.

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

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

**REVOCATION OF CERTIFICATE OF EXEMPTION FROM COVERAGE SHALL BE
EFFECTIVE THIRTY DAYS AFTER RECEIPT.**

Return completed form to:

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

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

TO: Builders Mutual Insurance Company

RE: _____
(Print Name of Owners or Partners)

doing business as _____
(Firm or Trade Name)

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

FEIN: _____ **NCDI #:** _____ **Unit #:** _____

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

Name of Owners or Partners
(Type or Print each officer's name and title under signature)

Date

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

THE COVERAGE SHALL BE EFFECTIVE THIRTY DAYS AFTER RECEIPT.

Return completed form to:

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

WITHDRAWAL OF ELECTION OF COVERAGE

TO: Builders Mutual Insurance Company

You are hereby notified that the undersigned hereby withdraws the election of coverage under the Workers' Compensation Law previously signed and filed and thereby exempts himself from the definition of the term "employee." I/we understand that the effect of this withdrawal of election of coverage is to eliminate me/us from the benefits provided by the Workers' Compensation coverage afforded to:

RE: _____
(Print Name of Owners or Partners)

doing business as _____
(Firm or Trade Name)

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

FEIN: _____ **NCDI #:** _____ **Unit #:** _____

Name of Owners or Partners
(Type or Print each officer's name and title under signature) **Date**

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

WITHDRAWAL OF ELECTION OF COVERAGE SHALL BE EFFECTIVE THIRTY DAYS AFTER RECEIPT.

Return completed form to:

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

EMPLOYER: THIS MUST BE *PROMINENTLY* POSTED. I.C. RULE 201.

WORKERS' COMPENSATION NOTICE And Instructions to Employers and Employees

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

— IMPORTANT THINGS TO DO IN CASE OF INJURY OR OCCUPATIONAL DISEASE —

The Employee Should:

1. Immediately give the employer notice in writing of injury or occupational disease. Failure to inform the employer within thirty (30) days after an injury or the development of most occupational diseases, or the refusal to accept medical services provided by the employer, may deprive the employee of the right to compensation.
2. File claim with the Industrial Commission within two (2) years of the accidental injury or two (2) years after the death, disability or disablement caused by an occupational disease. (The Commission's Form 18 may be used to give notice to employer and to file a claim.) In case of fatal injury, claim must be filed by one or more dependents or next of kin of the deceased employee within two years after such death.
3. If no agreement is reached with the employer with regard to payment of compensation for injury or occupational disease, or if a disagreement develops over compensation due, the employee should promptly request the Industrial Commission to hold a hearing to decide the issues. Benefits may be denied if the request is made more than two (2) years after the date of injury or last payment of cash compensation.

The Employer Should:

1. Provide all necessary medical, surgical, hospital and rehabilitation services reasonably required to effect a cure, give relief and lessen the period of the employee's disability. N.C.G.S. §97-25. Keep a record and report to insurance carrier/compensation administrator ALL injuries suffered by its employees on the Commission's Form 19. The employer, or the carrier/administrator on its behalf, must mail a Form 19 report to the Industrial Commission within five (5) days of the occurrence or report of an injury causing more than one day's absence from work or \$2,000.00 or more in medical treatment, other than treatment provided at the work place. N.C.G.S. §97-92.
2. Pay compensation in accordance with the provisions of the Workers' Compensation Act for disability. Agreements between employer and employee to pay compensation must be submitted to the Industrial Commission for approval.

Información sobre alivio medico y monetario para heridas ocurriendo al lugar del trabajo.

NORTH CAROLINA INDUSTRIAL COMMISSION
4340 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4340
(919) 807-2500

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

The filing of this report by an employer is required by law. It does not satisfy the employee's obligation to file a claim.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

This form MUST be transmitted to the Industrial Commission through Your Insurance Carrier.

The use of this form is required under the provisions of the Workers' Compensation Act.

Employee's Name _____		Employer's Name _____		() Telephone Number _____	
Address _____		Employer's Address _____		City _____	State _____ Zip _____
City _____	State _____	Zip _____	Insurance Carrier _____	Policy Number _____	
() Home Telephone _____		() Work Telephone _____		() Carrier's Address _____	
Social Security Number _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth _____	() Carrier's Telephone Number _____	() Fax Number _____

Employer	1. Give nature of employer's business _____
	2. Location of plant where injury occurred County _____ Department _____ State if employer's premises _____
Time And Place	3. Date of injury / / 4. Day of week _____ Hour of day : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
	5. Was employee paid for entire day _____ 6. Date disability began / / <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
	7. Date you or the supervisor first knew of injury / / 8. Name of supervisor _____
Person Injured	9. Occupation when injured _____
	10. (a) Time employed by you _____ (b) Wages per hour \$ _____
	11. (a) No. hours worked per day _____ (b) Wages per day \$ _____ (c) No. of days worked per week _____
	(d) Avg. weekly wages w/ overtime \$ _____ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. \$ _____ per
Cause And Nature Of Injury	12. Describe fully how injury occurred and what employee was doing when injured _____ (Statement made without prejudice and without vouching for correctness of information)
	13. List all injuries and specify body part involved (e.g. right hand or left hand) _____
	14. Date & hour returned to work / / at : .M. 15. If so, at what wages \$ _____ per
	16. At what occupation _____ 17. Employee's salary continued in full? _____
	18. Was employee treated by a physician _____
Fatal Cases	19. Has injured employee died _____ 20. If so, give date of death (Submit Form 29) / /

Employer name _____ Date Completed / /

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log: _____	Date Hired: / /	Time Employee began work on date of incident: : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility: _____	Address: Street/City/Zip/Telephone _____		ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No Overnight stay? <input type="checkbox"/> Yes <input type="checkbox"/> No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

For IC use ONLY

Nature _____
Body _____
Cause _____
SIC _____
Coder _____

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This report must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para certiorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN [*I.C. FILE NUMBER*] (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.

STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act Employer FEIN _____

Employee's Name _____

Employer's Name _____ Telephone Number _____

Address _____

Employer's Address _____ City _____ State _____ Zip _____

City _____ State _____ Zip _____

Insurance Carrier _____

() Home Telephone _____ () Work Telephone _____

Carrier's Address _____ City _____ State _____ Zip _____

Sex M F Date of Birth _____ / _____ / _____

() Carrier's Telephone Number _____ () Fax Number _____

Year:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Amount Earned			
Jan.																																			
Feb.																																			
Mar.																																			
Apr.																																			
May																																			
June																																			
July																																			
Aug.																																			
Sept.																																			
Oct.																																			
Nov.																																			
Dec.																																			
																																			Total

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? _____

If so, state weekly value thereof: \$ _____.

MAIL TO:
NCIC - CLAIMS SECTION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349

The undersigned employer of _____
(Name of Employee)
who alleges an injury on the _____ of _____,
(Day) (Month) (Year)

while in the employment of the undersigned, does hereby certify that the above is a true and correct statement of days worked and earnings of this employee during the 52 weeks immediately preceding the injury (or during the above weeks and parts thereof, if employed for less than 52 weeks) and while engaged in the occupation in which the employee was allegedly injured.

Employer
By _____
Authorized Signature

Date Signed

To Employer: Making a false statement for the purpose of denying workers' compensation benefits may result in civil or criminal penalties.

INSTRUCTIONS

This form must be completed and filed with the Commission in all cases resulting in death unless maximum compensation rate is stipulated. It must also be filed in any other case if there is a disagreement about earnings or if the Commission requests it.

In preparing this form, place an X in the proper squares to indicate days paid in full. Days the employee is on paid vacation leave and/or paid sick leave should be marked with an X. Leave blank squares to indicate days not paid in full for any reason. Total earnings for each pay period should be placed in the proper column. If the employee's job or pay rate was changed during the reported period, this should be noted, with an indication as to the nature of the change.

The employer code number and the carrier code number, if any, must be inserted in the proper place at the upper right-hand corner of the form.

ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

IC File # _____
 Emp. Code # _____
 Carrier Code # _____
 Carrier File # _____
 Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name _____	()	Employer's Name _____	Telephone Number _____
Address _____		Employer's Address _____	City _____ State _____ Zip _____
City _____ State _____ Zip _____		Insurance Carrier _____	
Home Telephone _____	Work Telephone _____	Carrier's Address _____	City _____ State _____ Zip _____
Social Security Number _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Carrier's Telephone Number _____	Fax Number _____
	Date of Birth _____		

Employees are entitled be reimbursed for mileage for medical treatment in workers' compensation cases at the rate of \$.31 a mile providing they travel 20 miles or more roundtrip. Special consideration will be given to employees who are totally disabled. No reimbursement is allowed for trips to purchase drugs or supplies unless medically necessary. These items must be purchased on visits to medical providers (G.S. § 97-25)

DATE	NAME OF MEDICAL PROVIDER	CITY	TOTAL MILES ROUNDTRIP
OTHER EXPENSES	If overnight stay is necessary, the following items will be approved as rendered (Receipts must be furnished for carrier's file)	Total motel expense:	
		Total meal expense:	
		Total parking & cab expense:	
		Total for other expenses:	
		Total Miles:	
		X \$0.31	
		Other expenses:	
		Total all expenses:	

I hereby certify that I have incurred all expenses listed above as a result of my workers' compensation injury.

Employee signature

Carrier's approval

Employee:
 Mail your bill in duplicate promptly to employer and/or insurance carrier

Employer or Carrier/Administrator: Travel may be reimbursed directly to the employee. It is not necessary to submit bills to the Commission for approval. Pay and retain copy in carrier's file.

RETURN TO WORK REPORT

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name _____

Employer's Name _____ Telephone Number _____

Address _____

Employer's Address _____ City _____ State _____ Zip _____

City _____ State _____ Zip _____

Insurance Carrier _____

Home Telephone _____ Work Telephone _____

Carrier's Address _____ City _____ State _____ Zip _____

Social Security Number _____ Sex M F Date of Birth _____

Carrier's Telephone Number _____ Fax Number _____

Employer: The use of this form is not appropriate when an employee has returned to work on a trial return to work basis pursuant to N.C. Gen. Stat. § 97-32.1, in which case Form 28T must be used. By using this form you are stating that this case is not a trial return to work and that one of the exclusions contained in NCIC Rule 404A(7) applies.

Important Notice To Employee: Your disability compensation has been stopped because you have returned to work. You are entitled to a trial return to work for a period not to exceed nine months, unless you have been released by an authorized treating physician to unrestricted work, in which case your trial return to work may be limited to 45 days. During your trial return to work, you may be entitled to partial disability compensation if, because of your on-the-job injury, you earn less wages now than before your injury. If your trial return to work is unsuccessful, you should complete form 28U in order to request that your compensation be reinstated.

THE EMPLOYER OR CARRIER/ADMINISTRATOR MUST COMPLETE THE FOLLOWING WHEN EMPLOYEE RETURNS TO WORK OTHER THAN ON A TRIAL RETURN TO WORK BASIS.

SECTION A. COMPLETE THE FOLLOWING:

1. Date of injury: _____
2. Date disability began: _____
3. Date returned to work: _____

SECTION B. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR REDUCED WAGES:

Employee is being paid at the rate of \$ _____ weekly.

SECTION C. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR A DIFFERENT EMPLOYER:

1. Name of that employer: _____
2. Address: _____
3. Telephone: _____

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR

TITLE

DATE

Employer: The original of this form shall be sent to the address below, and a copy sent to the employee and the employee's attorney of record, if any. A Form 28B must be filed to report the amount and last date compensation and/or medical compensation were paid.

MAIL TO:

**NCIC - CLAIMS SECTION
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349**

**NOTICE OF TERMINATION OF COMPENSATION BY
REASON OF TRIAL RETURN TO WORK
G.S. 97-18.1(b) AND G.S. 97-32.1**

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name _____			Employer's Name _____ () Telephone Number _____		
Address _____			Employer's Address _____ City _____ State _____ Zip _____		
City _____	State _____	Zip _____	Insurance Carrier _____		
() _____	() _____	() _____	Carrier's Address _____ City _____ State _____ Zip _____		
Home Telephone _____	Work Telephone _____	Carrier's Address _____	Carrier's Telephone Number _____ Fax Number _____		
() _____	() _____	() _____			
Social Security Number _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth _____			

Important Notice To Employee: Your disability compensation has been stopped because you have returned to work. You are entitled to a trial return to work for a period not to exceed nine months, unless you have been released by an authorized treating physician to unrestricted work, in which case your trial return to work may be limited to 45 days. During your trial return to work, you may be entitled to partial disability compensation if, because of your on-the-job injury, you earn less wages now than before your injury. In order to request that your compensation be reinstated if your trial return to work is unsuccessful, you should complete Form 28U, which may be obtained by calling (800) 688-8349. In addition, you should notify an appropriate person at the company named below in order to request that your compensation be reinstated:

NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR _____	ADDRESS _____	TELEPHONE NUMBER _____
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When an employee returns to work other than on a trial return to work basis [see I.C. Rule 404A(7)], Form 28 must be used.

EMPLOYER: COMPLETE THE FOLLOWING.

- Date of injury: _____ 2. Date disability began: _____
- Date temporary total compensation was/will be terminated: _____
- Date the employee returned/will return to work: _____
 at the same or greater wages, than received at the time of injury, or
 at reduced wages which were/are paid at the rate of \$ _____ weekly.
 If employee has returned to work at reduced wages, is employee entitled to compensation for partial disability pursuant to N.C. Gen. Stat. § 97-30? yes no
 If "Yes", submit proper Form, such as Form 26 or Form 62
 If not, explain: _____
- If different employment has been verified, name of employer: _____
 Address: _____
 Telephone: () _____

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR _____	TITLE _____	DATE _____
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Employer: The original of this form shall be mailed to the address below, and a copy sent to the employee and the employee's attorney of record, if any. Form 28B must be filed to report the amount and last date compensation and/or medical compensation were paid.

MAIL TO: **NCIC CLAIMS SECTION**
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349

NOTICE

Post Accident Drug/Alcohol Policy

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

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

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

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

BMIC Drug Testing Acknowledgment

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

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

This ____ day of _____, _____.

Employee Signature

Employee Name (Print)

Policyholder Representative Signature

AVISO
Reglamento de Examen de Drogas y Alcohol

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

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

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

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

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

Builders Mutual Insurance Company
Reconocimiento del examen de drogas y alcohol

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

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

En este día _____ de _____ del 20____.

Firma del empleado

Nombre de empleado

Firma del asegurado