Builders Mutual®
INSURANCE COMPANY
Where Builders Come First®

YOUR WORKERS' COMPENSATION POLICY GUIDE
South 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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- Corporate Office Notice to Reject (form 5)
- Report of Injury (Form 12-A)
- Statement of Earnings of Injured Employee (Form 20)
- SC Post Offer-of-Employment Medical Inquiry

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 $1,500, 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 $1,500. 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 $1,500. 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 $1,500 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
- Failure to meet Risk Management or Underwriting requirements and standards
- Determination that continuation would jeopardize solvency or place insurer in violation of insurance laws
- Violation of policy terms or conditions
- Material misrepresentation on the application
- Substantial change in the risk assumed if such change should not have been forseen by the insurer or contemplated in the rate
- Substantial breach of contractual duties, warranties, or conditions
- 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 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

Sole Proprietors/Partners – Sole proprietors/partners are excluded from a workers' comp policy but may elect to be covered by notification to BMIC via either written communication or on the ACORD 130 application.

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

Compliance Poster (Form 2) - The South Carolina Workers' Compensation Act requires this notice be posted in a conspicuous location where ***all*** employees can see it.

Corporate Officer Notice to Reject (Form 5) - Corporate officers are automatically included for coverage pursuant to the South Carolina Workers' Compensation Act unless exemption is made on this form. Withdrawal of a previous rejection must be submitted to BMIC in writing.

Report of Injury (Form 12-A) – The law requires you as the employer to report any injury within 10 business days of occurrence and knowledge. Failure to do so will result in fines of between $10 and $100. Prompt reporting will aid with prompt payment o f compensable claims. A claims representative will complete this form if the injury is reported by telephone. Copies of the form will be mailed to the employer.

Statement of Earnings of Injured Employee (Form 20) – When reporting an accident that requires the injured employee to be out of work for more than seven days, this form must be completed. A copy of the completed form must be provided to the injured employee within 30 days of the date compensation begins. The employer shall report *gross* wages and shall include *gross* pay allowed for vacations, bonuses, overtime and allowances of any kind made to an employee in lieu of wages as specified in a wage contract. Failure to file and/or serve this form as set forth above may result in a $100 fine and the possibility of an inflated compensation rate determined by a Commissioner.

Second Injury Fund
The Second Injury Fund functions within the South Carolina Workers' Compensation System. It protects employers from having a higher cost for an employee's injury when that injury, combined with a prior injury or disability, produces medical costs or a disability that is substantially greater than the accident alone would have produced.

South Carolina Post Offer-of-Employment Medical Inquiry – Completion of this form by employees is requested to assist employers in meeting the knowledge requirement of the South Carolina Second Injury Fund.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

CORPORATE OFFICER NOTICE TO REJECT

To the Employer of the Undersigned and the Employer's Insurance Carrier:

The undersigned officer rejects the terms, conditions, and provisions of the South Carolina Workers' Compensation Act and elects to pursue compensation for personal injuries under the common law and statutes of South Carolina.

As provided by law (Section 42-1-520), "An officer of a corporation who elects not to operate under this title, shall, in any action to recover damages for personal injury or death brought against an employer accepting the compensation provisions of this title, proceed at common law and the employer may avail himself of the defenses of contributory negligence, negligence of a fellow servant, and assumption of risk, as such defenses exist at common law."

This notice becomes effective on the date listed below, no sooner than the day following the date signed by the corporate officer.

** PLEASE PRINT OR TYPE ALL INFORMATION ** ORIGINAL SIGNATURES REQUIRED **

Name of Officer _____ Corporate Title _____

Street Address _____ Post Office Box _____

City _____ State _____ Zip _____

Social Security Number _____

Area Code _____ Telephone Number _____

Signature of Officer _____ Date _____

Name of Business (Legal Name) _____

Street Address _____ Post Office Box _____

City _____ State _____ Zip _____

Federal Employer ID # _____

Area Code _____ Telephone Number _____

Effective Date _____

Subscribed and sworn to me this _____ day of _____, _____.

_____ My commission expires: _____
Notary Public

This form may be used when an officer desires to become exempt from the provisions of the South Carolina Workers' Compensation Act. For additional information regarding the provision of Section 42-1-520 and this form, contact your insurance carrier or the South Carolina Workers' Compensation Commission, Coverage and Compliance Division, Post Office Box 1715, Columbia, South Carolina 29202-1715, (803)737-5709.

EMPLOYER (NAME AND ADDRESS INCL. ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #

SIC CODE

EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS AND PHONE NO.)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

[M] MALE
[F] FEMALE
[U] UNKNOWN

MARITAL STATUS
UNMARRIED
[U] SINGLE/DIVORCED
[M] MARRIED
[S] SEPARATED
[K] UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

RATE

PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE **BEGAN WORK** ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE

TYPE OF INJURY/ ILLNESS

PART OF BODY AFFECTED

DID INJURY/iLLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

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

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

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

CAUSE Of INJURY CODE

DATE RETURNED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

[0] NO MEDICAL TREATMENT
[1] MINOR: BY EMPLOYER
[2] MINOR CLINIC/HOSP
[3] EMERGENCY CARE
[4] HOSPITALIZED > 24 HRS.
[5] FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER

SEE BACK FOR IMPORTANT STATE INFORMATION/SIGNATURE

WCC FORM 12A

Print

WITH

Reset Form

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES: Enter all dates in MM/DD/YY format.

SIC CODE: This is the code which represents the nature of the employers business which is contained in the Standard Industrial Classification Manual published by the Federal Off ice 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 deigned by statute.

CONTACT NAME/PHONE NUMBER: Enter the name of the individual at the employers 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.

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: decorators 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 the most recent disability period on which the employee returned to work.

P.O. Box 1715 •1612 Marion Street
Columbia, South Carolina 29202-1715
(803)737-5700

Carrier File # _____
Carrier Code # _____
Employer FEIN _____

Claimant's Name _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Employer's Name _____

Address _____ City _____ State _____ Zip _____

Insurance Carrier _____

Preparer's Name _____ Phone # _____

A. Total Wages Paid

Date of injury: _____ (month day year)

1. Check Applicable Method:
   - ☐ Report of earnings of injured employee based on four completed quarters.
   - ☐ Report of earnings of injured employee who did not complete four quarters based on actual time worked.
   - ☐ Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire Date: _____
   - ☐ Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just. (Attach documentation to show how average weekly wage and compensation rate were calculated.)

2. List total wages paid as reported to Employment Security Commission on the Employer Quarterly Contribution and Wage Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st	_____	_____
2nd	_____	_____
3rd	_____	_____
4th	_____	_____

Total Paid 2. _____

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. _____

4. Add lines 2 and 3. **TOTAL WAGES PAID:** 4. _____

5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. _____

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).

AVERAGE WEEKLY WAGE: 6. _____

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. _____

8. The compensation rate is as follows (choose one):
   - ☐ When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
   - ☐ When the estimated compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $75.00. Enter $75.00 on line 8.
   - ☐ When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line-8.
   - ☐ Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8- _____
   - ☐ The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8. _____

Employees representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ONLINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723.

SOUTH CAROLINA
POST-OFFER-OF-EMPLOYMENT MEDICAL INQUIRY

Completion of this report is requested to assist your employer in meeting the knowledge requirement of the South Carolina Second Injury Fund.

Name_____Department_____Position_____

A. To the best of your knowledge do you have or have had any of the following medical problems?

Answer YES or NO

___1. **Epilepsy**
___2. **Diabetes**
___3. **Cardiac Disease**
___4. **Arthritis**
___5. **Amputated foot, leg, hand or arm**
___6. **Loss of sight** of one or both eyes or partial loss of uncorrected vision of more than 75% bilaterally
___7. **Residual disability from Polio**
___8. **Cerebral palsy** – Do you have a weakness or stiffness of arms, legs or other body parts that resulted from birth, injury or diseases? Any spasticity?
___9. **Multiple sclerosis**
___10. **Parkinson's disease**
___11. **Cerebral vascular accident** – Stroke or ruptured blood vessel in the head
___12. **Tuberculosis**
___13. **Silicosis** – Chronic cough emphysema or other lung problems due to inhalation of dust
___14. **Mental retardation**
___15. **Psychoneurotic disability** which involved treatment in a recognized medical or mental institution
___16. **Hemophilia** – Do you bleed easily and have a hard time stopping the bleeding?
___17. **Chronic osteomyelitis** – Long-term infection of bones or sores of the skin
___18. **Ankylosis of joints** – Joints that are stiff and will not fully move. Frozen joints.
____19. **Hyperinsulism** – Excessive insulin in the blood with low blood sugar and periods of weakness or fainting due to low blood sugar
____20. **Muscular dystrophy**
____21. **Arteriosclerosis** – Poor circulation, cold extremities, pain in legs while walking
____22. **Thrombophlebitis** – Infection or inflammation of veins in legs – swelling or tenderness in calves of legs
____23. **Varicose veins**
____24. **Heavy metal poisoning**
____25. **Ionizing radiation injury** – Have you been exposed to radiation and have developed Sores that did not heal, vomited or bled freely?
____26. **Compressed air sequelas** – Have you ever had the bends? Problems produced by flying at high altitude or problems resulting from exposure to high atmospheric pressure as in scuba diving?
____27. **Ruptured disc**
____28. **Hodgkin's disease**
____29. **Brain damage**
____30. **Deafness**
____31. **Sickle-cell anemia**
____32. **Cancer**
____33. **Pulmonary disease**
____34. **Degenerative disc disease**
____35. **Spondylosis**
____36. **Spondylolisthesis**
____37. **Chondromalacia**
____38. **Hepatitis**
____39. **HIV**

If you listed ARTHRITIS, please identify the parts of the body affected:

_____

For "yes" responses above, indicate the nature of injury or illness and name of physician in Remarks.

Remarks: _____

_____

_____

_____

_____

B. Has any doctor ever restricted your activities?

___ YES ___ NO

If so, please list the medical condition, what type of restrictions placed, whether these restrictions were temporary or permanent, and whether you are presently under these restrictions.

_____

_____

_____

C. Have you ever been assessed any percentage of permanent disability to any part of your body for any reason whatsoever?

___ YES ___ NO

If so, please explain:

_____

_____

_____

D. Are you presently under any medical treatment by a doctor, chiropractor, psychiatrist, psychologist or other health care provider?

___ YES ___ NO

If so, please list the medical condition(s) being treated, the name of the doctor(s), field of specialty, and address and telephone number.

If applicable, please list the names and addresses of any hospitals where psychiatric or psychological treatment was provided and dates.

_____

_____

_____

E. Are you presently taking any medication?

___ YES ___ NO

If yes, please list the name of the medication, the medical condition being treated, and the name, address and telephone number of the doctor who prescribed the medication.

_____

_____

_____

F. Have you ever had surgery to any part of your body?

___ YES ___ NO

If yes, please list the part(s) of the body operated on, the type of operation performed, the date of the operation, the name of the hospital, if any, where the operation was performed, and the name, address, and phone number of the doctor performing the surgery.

_____

_____

_____

G. Have you ever received treatment for your back, neck, knees or lower extremities from a doctor, chiropractor, therapist or other health care provider?

___ YES ___ NO

If yes, please list the name, address, and phone number of all doctors, chiropractors, therapist or other health care provider who provided such treatment, the dates of the treatment and the diagnosis provided by the doctor, chiropractor, therapist, or other health care provider.

_____

_____

_____

H. Have you ever had an injury that required you to miss time from work?

___ YES ___ NO

If yes, please list the type of injury, the amount of time missed from work, whether the condition was fully resolved or if it left you with any impairment, and whether you returned to work.

_____

_____

_____

I. Are you aware of any condition or injury that might impair or limit your ability to work for this company?

___ YES ___ NO

If yes, please describe the condition or injury.

_____

_____

_____

_____

I HAVE READ AND FULLY UNDERSTAND THE ABOVE.

Employee Applicant: _____ Date: _____

Employer Signature: _____ Date: _____

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 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.

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