



## **YOUR WORKERS' COMPENSATION POLICY GUIDE Tennessee**

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 20<sup>th</sup> 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](mailto:premiumaccounting@bmico.com).

#### Monthly Bill 10-Pay

For those whose annual premium is greater than \$750, 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 \$750. 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 \$750. 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 \$750 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](http://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**

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
- 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
- If the named insured is convicted of a crime that involves an act increasing a hazard insured against
- Fraud or material misrepresentation written by the insured or his representative on the application or in the pursuit of a claim

Please note that, 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 non-compliance 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](http://buildersmutual.com/audit).

#### *Subcontractors*

Subcontractors can represent an additional exposure to loss for you and the insurance company. 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 may be treated as remuneration and a premium charge will be made.

Effective March 1, 2011 policyholders will not be charged for exposures of subcontractors who are a sole proprietor, partner or officer of a corporation, or member of a limited liability company (and does not have employees) who have obtained a "Certificate of Election to be Exempt" from the Secretary of State. Policyholders must obtain a copy of this certificate prior to hiring the subcontractor and all certificates must be kept on file for review at the time of policy audit.

### **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](http://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](http://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](http://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](mailto: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.

**Agreement of General Contractor to Provide Workers' Compensation Coverage to Subcontractor (Form I-15)** – This form allows the general contractor to withhold premiums from the sub's payroll to cover the subcontractor. It must be notarized and filed in triplicate; the original will be submitted to the Tennessee Department of Labor and Workforce Development; the first copy should be submitted to the BMIC Underwriting department, and the second copy should be kept for the general contractor's records.

**Employer's First Report of Injury (Form C-20)** – The law requires you as the employer to report an injury within one working day of knowledge of the injury on this form. The injured employee must sign this form. If the employee cannot sign or refuses to sign this form, a written explanation must be attached.

**Wage Statement (Form C-41)** – When reporting an accident that requires the injured employee to be out of work for more than seven days, this form must be completed. If the injured employee has been employed for a year or more, gross wages and days worked for a period of 52 weeks prior to the injury will be needed to calculate the average weekly wage and compensation rate. If the injured employee has been employed less than a year, the statement should show all days worked and the gross earnings for this period of time.

**Agreement Between Employer/Employee Choice of Physician (Form C-42)** – The employer must provide an injured employee with a list of three physicians and one alternate physician. You are encouraged to contact BMIC immediately if you need assistance in selecting your panel of physicians.

**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT**  
**Division of Workers' Compensation**  
**Nashville, Tennessee 37243-0661**

**AGREEMENT OF GENERAL CONTRACTOR TO PROVIDE WORKERS' COMPENSATION COVERAGE TO SUBCONTRACTOR**

**NOTICE OF AGREEMENT**

To the Workers' Compensation Director:

You are hereby notified that the undersigned Subcontractor, being engaged as such by the undersigned General Contractor, hereby elects to come under the provisions of the Tennessee Workers' Compensation Law. This agreement to provide workers' compensation coverage to this Subcontractor does not provide workers' compensation coverage to this Subcontractor under any other contract to any other General Contractor.

**GENERAL CONTRACTOR'S AFFIRMATION**

\_\_\_\_\_ Firm Name of General Contractor

\_\_\_\_\_ Signature of General Contractor

\_\_\_\_\_ FEIN Number

\_\_\_\_\_ Address (Street, City, State, Zip)

\_\_\_\_\_ Date

Subscribed and sworn to me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_ Signature of Notary Public

\_\_\_\_\_ Date Commission Expires

**SUBCONTRACTOR'S AFFIRMATION**

\_\_\_\_\_ Signature of Subcontractor

\_\_\_\_\_ Social Security Number

\_\_\_\_\_ Address (Street, City, State, Zip)

\_\_\_\_\_ Date

Subscribed and sworn to me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_ Signature of Notary Public

\_\_\_\_\_ Date Commission Expires

This form must be completed in triplicate: (1) the original must be sent to the Workers' Compensation Division, (2) a copy must be filed with the workers' compensation insurance company, and (3) a copy must remain with the General Contractor or contract carrier for workers' compensation premium audit.

**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT  
EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS**

**C20**

CLAIMS ADM/CARRIER	JURISDICTION CLAIM # (STATE FILE #)		CLAIM TYPE CODE <input type="checkbox"/> MED ONLY <input type="checkbox"/> INDEMNITY <input type="checkbox"/> BECAME LOST TIME <input type="checkbox"/> BECAME MED ONLY <input type="checkbox"/> NOTIFY ONLY <input type="checkbox"/> TRANSFER		<p>The use of this form is required under the provisions of the Tennessee Workers' Compensation Law and must be completed and filed with your insurance carrier immediately after notice of injury.</p> <p><i>It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.</i></p> <p>If you have questions, the state now has a benefit review system where a Workers' Compensation Specialist can provide assistance. Call 1-800-332-2667 (TDD).</p>		
	CLAMS ADM CLAIM # (INSURER CLAIM #)						
	OSHA LOG CASE #						
	NAME OF INSURANCE CARRIER		CARRIER FEIN				
	CLAIMS ADMIN FIRM NAME (if different from carrier)		FEIN OF CLMS ADM				
	CLAIMS ADJUSTER NAME		CLMS ADJ PHONE #				
	CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2		CITY	STATE			
E EMPLOYER	EMPLOYER NAME		EMPLOYER FEIN		SIC CODE	PHONE NUMBER	
	EMPLOYER ADDRESS LINE 1 AND LINE 2				NATURE OF BUSINESS		
	CITY	STATE	ZIP	INSURED REPORT NUMBER	EMPLOYER LOCATION #		
POLICY	INSURED NAME (parent co. if different than employer)		POLICY NUMBER		EFF DATE	EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL TIME/REGULAR <input type="checkbox"/> PART TIME <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> APPRENTICE FULL TIME <input type="checkbox"/> APPRENTICE PART TIME	
	SELF INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO				EXP DATE		
EMPLOYEE	EMPLOYEE LAST NAME		PHONE INCL AREA CODE		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		
	FIRST	MI	DEPARTMENT REGULARLY WORKED		OCCUPATION DESCRIPTION		
	ADDRESS LINE 1 & 2						
	CITY	STATE	ZIP	MARITAL STATUS <input type="checkbox"/> UNMARRIED, SINGLE, DIVORCED	<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	NCCI CLASS CODE	
	SSN	DATE OF BIRTH	DATE OF HIRE				
WAGE	WAGE \$	PERIOD <input type="checkbox"/> HOURLY <input type="checkbox"/> DAILY	<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY	NUMBER OF DAYS WORKED PER WEEK	SALARY CONTINUED IN LIEU OF COMPENSATION <input type="checkbox"/> YES <input type="checkbox"/> NO		
					FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO		
ACCIDENT/INJURY	DATE OF INJURY		TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> COULD NOT BE DETERMINED		TIME EMPLOYEE BEGAN WORK ON INJURY DATE <input type="checkbox"/> AM <input type="checkbox"/> PM		
	DATE EMPLOYER NOTIFIED OF INJURY		BODY PART AFFECTED CODE		NATURE OF INJURY CODE	CAUSE OF INJURY CODE	
	DATE CLAIM ADM NOTIFIED OF INJURY		How injury or illness occurred. Describe the incident including what the employee was doing just before, the part of the body affected and how, and object or substance that directly harmed the employee.				
	DATE LAST DAY WORKED						
	DATE DISABILITY BEGAN						
	RETURN TO WORK DATE (IF APPLICABLE)						
	DATE OF DEATH (IF APPLICABLE)		IF DEATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP <input type="checkbox"/> WIDOW <input type="checkbox"/> FATHER                      _____ SISTER                      TOTAL # DEPENDENTS <input type="checkbox"/> WIDOWER                      _____ DAUGHTER                      _____ BROTHER <input type="checkbox"/> MOTHER                      _____ SON                      _____ HANDICAPPED CHILD				
	DID INJURY/ILLNESS OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO						
	ADDRESS WHERE INJURY OCCURRED (if other than employer's premises)					COUNTY OF INJURY	
		CITY	STATE	ZIP	CITY	STATE	ZIP
TREATMENT	PHYSICIAN NAME			HOSPITAL OR OFF SITE TREATMENT NAME			
	ADDRESS LINE 1 AND 2			ADDRESS LINE 1 AND 2			
	CITY	STATE	ZIP	CITY	STATE	ZIP	
	INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT		<input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR BY CLINIC/HOSPITAL	<input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> EMERGENCY CARE	<input type="checkbox"/> FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED		
OTHER	DATE PREPARED	PREPARER'S NAME & TITLE		PREPARER'S COMPANY NAME		PHONE NUMBER	

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

Nashville, Tennessee 37243-0661

WAGE STATEMENT

*It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.*

EMPLOYEE: \_\_\_\_\_ SSN: \_\_\_\_\_ STATE FILE # \_\_\_\_\_

In order to determine the correct rate of compensation to be paid to the above injured party, please fill in the schedule below and return it promptly. This information is required by law and no agreement for payment of compensation can be made until it has been received. Please complete 52 weeks prior to date of accident.

Please describe allowances of any character made in lieu of wages that must be deemed a part of employee's earnings: \_\_\_\_

If the average weekly wage is not based on fifty-two weeks of earnings proceeding the date of injury, please show your computation below: \_\_\_\_\_

WEEK	NO. DAYS	WEEK ENDING	GROSS WAGES	WEEK	NO. DAYS	WEEK ENDING	GROSS WAGES
1				27			
2				28			
3				29			
4				30			
5				31			
6				32			
7				33			
8				34			
9				35			
10				36			
11				37			
12				38			
13				39			
14				40			
15				41			
16				42			
17				43			
18				44			
19				45			
20				46			
21				47			
22				48			
23				49			
24				50			
25				51			
26				52			
						TOTAL PAID	

RATE PER DAY \_\_\_\_\_ PER HOUR \_\_\_\_\_ AVERAGE PER WEEK \_\_\_\_\_

I hereby certify that the above is a true and correct account, as taken from our timebooks or pay-roll records, of the wages paid to the above-named injured employee for the periods indicated.

Date \_\_\_\_\_ 20\_\_\_\_ EMPLOYER  
 BY \_\_\_\_\_  
 TITLE \_\_\_\_\_

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

Nashville, Tennessee 37243-0661

Website: www.state.tn.us/labor-wfd/wcomp.html

Telephone: 1-800-332-2667

EMPLOYEE'S CHOICE OF PHYSICIAN

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

State File Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Employee: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ FEIN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PANEL OF PHYSICIANS

Tennessee Code Annotated §50-6-204(a)(4)(A) requires an employer to offer a panel of three physicians to the injured employee. If the injury is a back injury the panel must be expanded to four, one of whom must be a chiropractor. Chiropractor visits are limited to 12 visits per back injury. The injured employee must select a physician from the panel.

Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is Physician a Specialist?  Yes  No If yes, give specialty: Ortho, Neuro, Chiro, etc. \_\_\_\_\_

Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is Physician a Specialist?  Yes  No If yes, give specialty: Ortho, Neuro, Chiro, etc. \_\_\_\_\_

Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is Physician a Specialist?  Yes  No If yes, give specialty: Ortho, Neuro, Chiro, etc. \_\_\_\_\_

Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is Physician a Specialist?  Yes  No If yes, give specialty: Ortho, Neuro, Chiro, etc. \_\_\_\_\_

Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is Physician a Specialist?  Yes  No If yes, give specialty: Ortho, Neuro, Chiro, etc. \_\_\_\_\_

I hereby have selected the following physician from the list provided to me by my employer:

Physician Chosen: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date Selected: \_\_\_\_\_

A copy of this form must be provided to the employee. The employer must keep the original form on file and upon request provide a copy to the Division of Workers' Compensation.

This form is required to be in compliance with Tennessee Code Annotated §50-6-204.

## NOTICE

### Post Accident Drug/Alcohol Policy

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

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

After each work related injury, a drug and alcohol test should be performed on the injured employee and all other employees whose conduct could have contributed to the accident if there is a reasonable possibility that drug and/or alcohol use by the injured employee and/or co-employees could have contributed to the injury or illness. The test will be performed at the time medical treatment is first administered and the cost of the test will be covered by Builders Mutual as a reasonable claims expense.

**If the treating medical facility refuses to administer a drug and alcohol test, contact the Claims department at 1-800-809-4862 while the injured is still at the facility. This will enable the Claims department to contact the provider to make arrangements to have a drug and alcohol test administered.**

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

### **BMIC Drug Testing Acknowledgment**

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

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

This \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employee Name (Print)

\_\_\_\_\_  
Policyholder Representative Signature

**AVISO**  
**Reglamento de Examen de Drogas y Alcohol**

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

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

Después de cada lesión relacionada con el trabajo, se debe realizar un examen de drogas y/o alcohol al empleado lesionado y a todos los empleados cuyo comportamiento pudo haber afectado el accidente, si existe la posibilidad del uso de drogas y/o alcohol por parte del empleado lesionado y/o los colaboradores pudo haber contribuido a la lesión o enfermedad. Este examen debe ser hecho en la primera consulta médica sin ningún costo para el empleado. Builders Mutual pagará por el examen.

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

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

Builders Mutual Insurance Company  
Reconocimiento del examen de drogas y alcohol

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

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

En este día \_\_\_\_\_ de \_\_\_\_\_ del 20\_\_\_\_.

\_\_\_\_\_  
Firma del empleado

\_\_\_\_\_  
Nombre de empleado

\_\_\_\_\_  
Firma del asegurado