Builders Mutual
INSURANCE COMPANY
Where Builders Come First®

YOUR WORKERS' COMPENSATION POLICY GUIDE
Tennessee

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

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

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

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

Also enclosed in this policy jacket:

Your Policy
Post Injury Drug/Alcohol Policy (post for employees)
BMIC Drug Testing Acknowledgement
Estimated Billing (invoice for any premium due)

PREMIUM ACCOUNTING

Payment Plans

Builders Mutual offers the following payment plans; policyholders may change plans at renewal only:

Monthly Self-Reporting

We know your payroll fluctuates throughout the year. With our convenient system of monthly reporting, your monthly premium is based on your actual payroll for the previous month. Policyholders will receive a monthly worksheet. Enter GROSS payroll by classification(s) for the period during the month coverage was in effect. If you did not have payroll during a month, mark "NO PAYROLL" on the report. Completed reports should be submitted with the appropriate premium payment to Builders Mutual by the 20th of each month.

- Online Monthly Self-Reporting is available on Builders Online Business. Simply login to BOB, enter your payroll and let the system calculate the amount due. Make an online payment to complete the process.
- Paper worksheets can be mailed to BMIC, PO Box 900017, Raleigh, NC 27675-00017 or emailed to: premiumaccounting@bmico.com.

Monthly Bill 10-Pay

For those whose annual premium is greater than $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

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

RISK MANAGEMENT

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

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

Resources

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

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

Spanish Website

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

Builders University

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

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

Courses offered include:

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

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

CLAIMS

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

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

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

Online: Login to Builders Online Business and select **Submit a Claim**

Drug testing
BMIC maintains a policy requiring post-injury drug and alcohol testing arising out of any alleged work-related accident. In order to receive workers' compensation coverage, **BMIC expects each employer to notify its employees of this Policy in order that they may be potentially eligible to receive workers' compensation benefits.**

Enclosed is a Notice of this Policy and an Acknowledgment Form which should be made available to all employees. In the event of an alleged on-the-job injury arising out of an alleged work-related accident, the employee will be tested at the time medical treatment is first administered. Pursuant to our policy, BMIC shall pay the cost of this Drug and Alcohol Test as a reasonable expense incurred at BMIC's request.

If the provider refuses to administer a drug and alcohol test, contact the Claims department at (800) 809-4861 while the injured person is at the medical facility. This will enable the Claims department to contact the medical provider to make arrangements to have a drug and alcohol test administered.

FORMS AND THEIR PURPOSE

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

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.

I-15

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.

LB-0301 (rev.8/99)

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

C20 EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

CLAIMS ADM/CARRIER

JURISDICTION CLAIM # (STATE FILE #)

CLAMS ADM CLAIM # (INSURER CLAIM #)

OSHA LOG CASE #

CLAIM TYPE CODE
- ☐ MED ONLY
- ☐ INDEMNITY
- ☐ BECAME LOST TIME
- ☐ BECAME MED ONLY
- ☐ NOTIFY ONLY
- ☐ TRANSFER

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 | ZIP

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.

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.

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).

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

SELF INSURED?
☐ YES ☐ NO

EFF DATE

EXP DATE

EMPLOYMENT STATUS CODE
- ☐ FULL TIME/REGULAR
- ☐ PART TIME
- ☐ PIECE WORKER
- ☐ SEASONAL
- ☐ VOLUNTEER
- ☐ APPRENTICE FULL TIME
- ☐ APPRENTICE PART TIME

EMPLOYEE

EMPLOYEE LAST NAME

PHONE INCL AREA CODE

FIRST | MI

DEPARTMENT REGULARLY WORKED

GENDER
- ☐ MALE
- ☐ FEMALE
- ☐ UNKNOWN

ADRRESS LINE 1 & 2

OCCUPATION DESCRIPTION

CITY | STATE | ZIP

MARITAL STATUS
- ☐ UNMARRIED, SINGLE, DIVORCED
- ☐ MARRIED
- ☐ SEPARATED
- ☐ UNKNOWN

NCCI CLASS CODE

SSN | DATE OF BIRTH | DATE OF HIRE

WAGE

WAGE $

PERIOD
- ☐ HOURLY
- ☐ DAILY
- ☐ WEEKLY
- ☐ BI-WEEKLY
- ☐ MONTHLY

NUMBER OF DAYS WORKED PER WEEK

SALARY CONTINUED IN LIEU OF COMPENSATION ☐ YES ☐ NO

FULL WAGES PAID FOR DATE OF INJURY ☐ YES ☐ NO

ACCIDENT/INJURY

DATE OF INJURY

TIME OF INJURY ☐ AM ☐ PM
☐ COULD NOT BE DETERMINED

TIME EMPLOYEE BEGAN WORK ON INJURY DATE ☐ AM ☐ 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
- ☐ WIDOW
- ☐ WIDOWER
- ☐ MOTHER
- ☐ FATHER
- ____ DAUGHTER
- ____ SON
- ____ SISTER
- ____ BROTHER
- ____ HANDICAPPED CHILD

TOTAL # DEPENDENTS

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

ADDRESS WHERE INJURY OCCURRED (if other than employer's premises)
CITY | STATE | ZIP

COUNTY OF INJURY

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
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYER
- ☐ MINOR BY CLINIC/HOSPITAL
- ☐ HOSPITALIZED > 24 HRS
- ☐ EMERGENCY CARE
- ☐ FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

DATE PREPARED | PREPARER' NAME & TITLE | PREPARER'S COMPANY NAME | PHONE NUMBER

LB-0021 (REV 12-01)

FORM C-41

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 _____

LB-0384 (rev. 8/99)

FORM C-42

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.

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