YOUR WORKERS' COMPENSATION POLICY GUIDE
Virginia

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.

Also enclosed in this policy jacket:

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

PREMIUM ACCOUNTING

Payment Plans
Builders Mutual offers the following payment plans (policyholders may change plans at renewal only):

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

- Online Monthly Self-Reporting is available. Login, enter your payroll and the system will calculate the amount due. You must make an online payment to complete the process.
- Paper worksheets can be mailed to Builders Mutual, PO Box 900017, Raleigh, NC 27675-00017 or emailed to: premiumaccounting@bmico.com.

Monthly Bill 10-Pay
For those whose annual premium is greater than $1,000, have steady payroll and want a fixed payment plan. This plan allows for 20% of the total amount (premium + expense constant) to be due at application and we will bill for the remaining 9 installments.

4-Pay, Quarterly
For those whose annual premium is greater than $1,000. This plan allows for 25% of the total amount (premium + expense constant) to be due at application. We will bill for the remaining 3 installments.

2-Pay, Semi-Annual
For those whose annual premium is greater than $1,000. This plan allows for 50% of the total amount (premium + expense constant) to be due at application. We will bill for the remaining installment.

Annual
Policies less than $1,000 in annual premium are required to be on the annual pay plan. In addition, policyholders who wish to pay one annual premium may select this plan. No deposit is required.

How to pay your bill
Mail: Send your remittance coupon along with your check to:
Builders Mutual Insurance Company
PO Box 900027, Raleigh, NC 27675-0027

Phone: Pay with credit/debit card, or electronic check. Call our **Customer Contact Center at (800) 809-4859,** Monday-Friday, 8am to 6pm EST.

Online: Pay with a credit/debit card, or electronic check. Go online to pay your bill: **buildersmutual.com/policyholders**

Auto-draft: Go online to register individual policies for an automated recurring payment option. Premium will be drafted directly from your checking account.

Go Paperless
Go online to select Go Paperless and receive your policy documents via email.

Returned Checks or Electronic Payments
All checks and electronic payments that are returned for insufficient funds or any other reasons will subject the policyholder to a $25.00 charge per payment.

Renewals
The policy will renew on the renewal date listed on the declaration page. However, policies that incur losses are subject to review by the Underwriting department for continued acceptability.

Cancellation
Cancellation of insurance coverage may result because of the following:

- Non-Payment of premium, including NSF returned check, failure to submit monthly self-audit worksheets, failure to submit to or pay year-end audit, failure to pay deposit balance
- Conviction of named insured of a crime which affects hazard that is insured against
- Fraud or material misrepresentation
- 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

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. Your failure to cooperate with any audit request may result in our 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 **buildersmutual.com/audit**.

Subcontractors

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

Workers' Compensation

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

Subcontractor waivers are *not* accepted.

Your records

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

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

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

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

RISK MANAGEMENT

When you define, identify, analyze and plan for the risks associated with your company's operations, you are protecting your bottom line. That's risk management. Builders Mutual has an entire risk management department dedicated to helping you do just that. As part of our services, we may contact you for a complimentary onsite visit by one of our experienced consultants. Thank you in advance for your assistance in scheduling this at a mutually agreeable time.

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

Resources

Visit the Risk Management section of our website and find numerous resources to help you develop your own safety program. Navigate to **buildersmutual.com/RM**; all the tools you need are right at your fingertips. Resources include:

- Selection of Tool Box talks to use during safety meetings.
- Sample safety policy to use as a baseline and customize to meet your needs.
- Selection of sample safety program modules to customize.
- Details on our Fall Protection Program and educational opportunities.
- WorkSafe 101 – "Know the Basics" New Employee Safety Orientation
- Safety products – Builders Mutual's online ordering site allows you to purchase safety equipment at discounted prices.

Spanish Resources

Builders Mutual offers product, risk management and audit resources online in Spanish. Risk Management tool box talks, the safety policy and safety program modules, Fall Protection Certification Program requirements and more are at your fingertips and are designed to be used by Spanish-speaking policyholders or Spanish-speaking employees. Additionally, you can request a jobsite safety consultation from a Spanish-speaking Risk Management consultant. To view audit information in Spanish, go to **buildersmutual.com/audit**.

Builders University

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

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

Courses offered include:

- WorkSafe 101 (1 hour)
- Fall Protection (4 hours)
- Enterprise Risk Management for Contractors (3 hours)
- Safety Pays: A Practical Approach to Safety on Your Jobsite (4 hours)
- OSHA 10-Hour Construction Industry Safety Course (10 hours usually broken into two days)
- OSHA 30-Hour Construction Industry Safety Course (30 hours usually broken into four days)
- Defensive Driving Course (4 hours)
- Safety Talks (customized to meet your needs.)

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

CLAIMS

Accidents happen, and when they do, you can rely on our claims department to respond with unparalleled service, speed, and individual attention. Policyholders are assigned a single point of contact who handles your claim from beginning to end. We will thoroughly review your workers' medical bills and case documents, strive to get your vehicles back on the road and equipment back in working order, and protect your interests in costly litigation.

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

By Email: wcnoticeofloss@bmico.com for workers' comp claims
otcnoticeofloss@bmico.com for all other claims

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

Claims Forms – Please become familiar with the following forms and their purpose. A brief description of each is given. The forms are included for future reference and use.

Employer's Workplace Notice (Form VWC1) – The Virginia Workers' Compensation Act requires this notice be posted in a conspicuous location where *all* employees can see it.

Employer's Accident Report (Form 3) – The law requires employers to report an accident immediately upon notification of an injury. After receiving notice of an accident or occupation disease, the employer must provide the employee with a panel of three physicians from which the employee must select a treating physician. If the employer fails to provide said panel, the employee may elect to receive treatment from any healthcare provider. If emergency care is required, the employer should provide a panel of physicians immediately upon treatment. The employer is encouraged to contact BMIC for assistance in selecting a panel of physicians. Please be advised that the Virginia Workers' Compensation Commission does not allow a chiropractor to be listed as a panel physician. *Important*: employer must use an original, beige form.

Wage Chart (Form 7A) – This form must be completed when reporting an accident that requires the injured employee to be out of work more than seven days. If the injured employee has worked with current employer for more than one year, gross wages and days worked for the 12 months prior to the accident should be used.

> *Example:*
> Date of Injury 5-1-00
> The Wage Chart should show "x" on all days worked from 5-2-99 through 5-1-00.

If the injured employee has worked less than 60 days, a Wage Chart should be completed based on the gross wages of a similarly-paid employee.

Rejection of Coverage Under the Virginia Workers' Compensation Act (Form 16A) – Corporate officers are automatically included for coverage pursuant to the Virginia Workers' Compensation Act unless exemption is made on this form.

Notice Terminating Prior Rejection of Coverage Under Virginia Workers' Compensation Act (Form 17A) – Filing this form allows corporate officers to revoke a previous rejection of coverage.

Virginia Contracting Classification Premium Adjustment Program (CCPAP) Workers' Compensation Premium Credit Application (Form 45-3B) – This form is applicable to qualifying employers engaged in contracting operations and is applicable to policies with effective dates on or after January 1, 1997.

Form VWC1

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.

2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.

3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.

4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.

2. Report the injury to the Commission through your carrier or directly to the Commission.

3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, Virginia 23220

1-877-664-2566
vwc.state.va.us

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

Employer's Accident Report

(formerly: Employer's First Report of Accident)
Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220
See instructions on the reverse of this form

The boxes to the right are for the use of the insurer	Reason for filing	VWC file number
	Insurer code or PEO Ref. No.	Insurer location
	Insurer claim number	

Employer

1. Name of employer (trading as or doing business as, if applicable)	2. Federal Tax Identification Number	3. Employer's Case No. (if applicable)
4. Mailing address	5. Location (if different from mailing address)	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name	7. Nature of business (NAICS code, if applicable)	
8. Name and Address of Insurer or self-insurer for this claim	9. Policy number	10. Effective date

Time and Place of Accident

11. City or county where accident occurred	12. Date of injury	13. Hour of injury ☐ a.m. ☐ p.m 13a. Time began work ☐ a.m. ☐ p.m	14. Date of incapacity	15. Hour of incapacity
16. Was employee paid in full for day of injury? ☐ Yes ☐ No		17. Was employee paid in full for day incapacity began? ☐ Yes ☐ No		
18. Date injury or illness reported	19. Person to whom reported	20. Name of other witness	21. If fatal, give date of death	

Employee

22. Name of employee (Last, First, Middle)		23. Phone number	24. Sex ☐ Male ☐ Female
25. Address		26. Date of birth 28. Social security number	27. Marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
29. Occupation at time of injury or illness (SOC code, if applicable)		30. Is worker covered by PEO policy? ☐ Yes ☐ No	31. Number of dependent children ☐
32. How long in current job?	33.Date of Hire	34. Was employee paid on a piece work or hourly basis? ☐ Piece work ☐ Hourly	
35. Hours worked per day ☐	36. Days worked per week ☐	37. Value of perquisites per week Food/meals $ Lodging $ Tips $ Other $	
38. Wages per hour $	39. Earnings per week (inc. overtime) $		

Nature and Cause of Accident

40. Machine, tool, or object causing injury or illness	41. Specify part of machine, etc.
42. Describe fully how injury or illness occurred	
43. Describe nature of injury or illness, including parts of body affected	43a. Overnight inpatient hospitalization? ☐ Yes ☐ No 43b. Treated in Emergency Room? ☐ Yes ☐ No
44. Physician (name and address)	45. Hospital or Clinic (name and address)

46. Probable length of disability	47. Has employee returned to work? ☐ Yes ☐ No	If yes 48. At what wage?	49. On what date?
50. EMPLOYER: prepared by (name, signature, title)		51. Date	52. Phone number
53. INSURER: (name of processor)		54. Date	55. Phone number
56. THIRD PARTY ADMINISTRATOR (if applicable)	57. Address		58. Phone number

This report is required by the Virginia Workers' Compensation Act

INSTRUCTIONS

Employer's Accident Report
(formerly Employer's First Report of Accident)
VWC Form No. 3

Employer

1. Fill out this form whenever one of your employees is injured. Provide all the information requested, except the information in the top right corner. **Please type or print all information in black ink.** Your signature is required on line 50 of the form.

2. Send the original beige form to your insurance carrier, claims servicing agency, or third party administrator for processing. If you are self-insured, send it to your organization's designated office for handling workers' compensation claims.

3. If you are an employer subject to OSHA record-keeping requirements, you may retain a copy of this completed form as a supplementary record of occupational injury or illness. Use block #3 (Employer's Case No.) to cross-reference your master log of accidents and illnesses.

4. If you need additional copies of this form, please request them from your insurance carrier, claims servicing agency, or third party administrator.

Insurance carriers, self-insured employers, Professional Employer Organizations (PEO's), and authorized representatives

1. For accidents meeting one of the seven criteria for establishing a Commission Case File,* submit the original beige form and one copy to the Virginia Workers' Compensation Commission at 1000 DMV Drive, Richmond VA 23220. The code for the reason for filing should be written at the top right of the form.

2. When processing these forms prior to transmittal to the Commission, please include the information requested at the top right of the form, verify that the carrier name and policy number given by the employer are accurate, and enter your name and phone number, and the date of processing at the bottom of the form.

3. Insurer code at the top right of the form refers to the five-digit code assigned by NCCI. If you are self-insured, it refers to a similar five-digit number assigned by the Virginia Workers' Compensation Commission. A PEO must use the VWCC reference number.

4. Additional copies of this form are available without cost by writing to the Commission. Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. Write to "Forms" at the listed Virginia Workers' Compensation Commission address.

5. On Lines 8 and 9, the employer or carrier is to give the name of the responsible carrier as set forth on the policy (line 8) and that carrier's policy number (line 9).

6. This form can be filed electronically. If you would like more information, please go to the Virginia Workers' Compensation Commission's Web site (www.vwc.state.va.us) or call us at (804) 367-2084.

---

*The criteria are (1) lost time exceeds seven days, (2) medical expenses exceed $1,000, (3) compensability is denied, (4) issues are disputed, (5) accident resulted in death, (6) permanent disability or disfigurement may be involved, and (7) a specific request is made by the Virginia Workers' Compensation Commission.

Wage Chart

Employer's Statement of Wage Earnings

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220

The boxes at the right are for the use of the insurer.	Reserved	VWC File Number
	Insurer Code	Insurer Location
	Insurer Claim Number	

	Employee		**Address**	
Name of Employee				Date of Accident
	Employer		**Address**	
Name of Employer				Employee's Social Security Number

Instructions:

- Indicate gross weekly earnings for the 52 weekly periods immediately **preceding** the date of accident.
- If injured employee has worked less than 12 months, the earnings for the time worked should be used. The earnings for a similar employees may be used if the employee has worked less than 60 days.
- Note that these earnings are GROSS earnings and include overtime and tips, before any deductions are made for taxes or Social Security. If there were any perquisites, please list the TOTAL value separately at the bottom of the chart.

Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime	Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime	Week No.	Week Ending Date	Days Worked	Gross amount paid, including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				**Totals**			
18				36							

Value of perquisites for entire year:

Total gross earning $ _____

Total weeks worked _____

Bonuses $ _____
Meals/Lodging $ _____
Meals Only $ _____
Temporary Lodging $ _____
House Rent $ _____
Tip Income $ _____

Electricity $ _____
Water $ _____
Telephone $ _____
Uniforms $ _____
Laundry $ _____

Total value of perquisites $_____

Total earnings & perquisites $ _____

VWC use only:

AWW: _____
CR: _____

INSURER OR EMPLOYER (include name & signature)	Date	Phone number

Officer/Manager Rejection of Coverage

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
(804) 205-3586

www.workcomp.virginia.gov

PLEASE COMPLETE FULLY AND LEGIBLY OR FORM CANNOT BE PROCESSED

FILING INSTRUCTIONS ON REVERSE SIDE

All Information Requested is Required

Corporation /LLC Name: _____

Address: _____

Suite/Bldg: _____

City: _____ State: _____ Zip: _____

Corporation: ☐ LLC: ☐

Business FEIN:
(Federal ID Number): _____

VA State Corporation
Identification No: _____

Insurance

Insurance Carrier or
Self Insured Group: _____

Policy Number: _____

Policy Period: _____

❖ **Ensure coverage is filed prior to submitting form to Commission**

Last Name: _____

First
Name: _____ MI: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

SSN: _____
Last Four Digits Required

Officer Title: ☐ President ☐ Treasurer ☐ Vice Pres
(Check One)
☐ Secretary ☐ Manager LLC (*) ☐ Other(**)

*Operating agreement or articles of org. must be included
**Corporate charter and bylaws must be included w/filing
❖ A Director or LLC member cannot Reject coverage
❖ Officer status will be verified in S.C.C.

Are you paid salary or wages on a regular basis at an agreed amount?

☐ Yes ☐ No
(Response Required)

Pursuant To the provisions of Section 65.2-300 of the Virginia Workers' Compensation Act, the undersigned hereby rejects the right to claim workers' compensation benefits for injuries by accident.

Signature of Officer/Manager	**Date signed :**
Signature of Employer	**Date notice received by Employer:**

This rejection of coverage shall be effective as of the last to occur i) the policy inception or; ii) the delivery of the notice to the employer, pursuant to § 65.2-300.

Complete section below for Agent or Agency to receive a copy of the 16A Approval

Agency Name _____	Agent Name _____
Address: _____	Agent Telephone: _____
City: _____ State: _____ Zip: _____	Agent Email: _____

INSTRUCTIONS

OFFICER/MANAGER
REJECTION OF COVERAGE (VWC FORM 16A)

FILE A SINGLE COPY OF THIS FORM WITH THE VIRGINIA WORKERS' COMPENSATION COMMISSION.

READ INSTRUCTIONS CAREFULLY PRIOR TO COMPLETING FORM.

1. Fill out this form when an officer of a corporation or a manager of an LLC elects to reject workers' compensation coverage for injury by accident under the Virginia Workers' Compensation Act.

2. The name of the corporation or LLC should be the same as the Charter by which the corporation or LLC is licensed. Use the mailing address used by the corporation or LLC to receive mail by the U.S. Postal Service.

3. Identify the entity by checking corporation or LLC. Provide the employer's Federal Identification Number (FEIN) and the State Corporation Commission Identification Number, if applicable.

4. *An Executive Officer means (i) the president, vice-president, secretary, treasurer or other officer, elected or appointed in accordance with the charter and bylaws of a corporation and (ii) the manager elected or appointed in accordance with the articles of organization or operating agreement of a limited liability company. A Director is not an executive officer and is not qualified to reject coverage under the Act.

5. Officer status will be verified by the Commission in State Corporation Commission (SCC). If you anticipate that SCC information is not current or the corporation is based out of state and not listed in SCC you may submit documentation of current officer status (e.g. minutes).

6. For a LLC manager, the operating agreement or articles of organization documenting the individual's manager status is required.

7. Provide all requested information for the officer or manager rejecting coverage. Officers of a corporation must check "Yes" or "No" to the questions regarding salary or wages.

8. Provide current workers' compensation insurance coverage information. Do not use such terms as "To Be Assigned," "Pending" or "Unknown." **Insurance coverage must be active** for approval, therefore please do not submit form listing expired coverage or coverage that is not yet filed. You may use the Insurance Coverage Search tool at: https://www.ewccv.com/cvs/ to verify coverage prior to submitting.

9. Signatures of the employer and officer/manager are required.

10. The effective date of the rejection of coverage in accordance with the statute is the last to occur: i) the policy inception or ii) the delivery of the notice to the employer, in accordance with the statute, section 65.2-101.

A copy of this notice must be provided to the employer. An additional copy must be filed with the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220.

A Rejection of Coverage is continuous unless a Termination of Prior Officer Rejection of Coverage (form 17A) is filed.

This form is available on our website at www.workcomp.virginia.gov or request copies by writing to the Commission.

Virginia Workers' Compensation Commission

1000 DMV Drive
Richmond, Va 23220

NOTICE TERMINATING PRIOR REJECTION OF COVERAGE UNDER THE VIRGINIA WORKERS' COMPENSATION ACT

EMPLOYER INFORMATION

_____
Corporate/L.L.C. Name

_____
Street Address

_____
City State Zip Code

☐ **Corporation**
OR
☐ **L.L.C.**
(Check One)

_____
Federal Identification Number

_____
Va. State Corporation Number

==========

OFFICER/MANAGER TERMINATING PRIOR REJECTION OF COVERAGE

_____
Name (Last, First and Middle Initial)

_____
Social Security Number

_____
Street Address

_____
City State Zip Code

_____
Title of Officer (Manager, if applicable)

==========

This is Notice that the undersigned hereby terminates the rejection of the right to claim compensation benefits on account of injuries by accident sustained under Virginia Workers' Compensation Act as provided in §65.2-300 and, in accordance with §65.2-300, hereby accepts the provisions of the Act.

_____ _____
Signature of Officer/Member **Date**

_____ _____
Signature of Employer (By) **Date**

_____ _____
Witness **Date**

A copy of this notice must be handed to the employer or sent by registered mail. An additional copy must be filed with the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220.

INSTRUCTIONS

Termination of Prior Rejection of Coverage

VWC Form 17A

File a single copy of this form with the Virginia Workers' Compensation Commission.

READ THESE INSTRUCTIONS CAREFULLY PRIOR TO COMPLETING THIS FORM.

1. Fill out this form whenever an officer of a corporation or a manager of an L.L.C. elects to terminate a prior rejection of coverage for an accident under the Virginia Workers' Compensation Act.

2. The name of the corporation/L.L.C. should be the same as the Charter by which the corporation or L.L.C. is licensed, and the same name used on the Form 16A when coverage was rejected. Use the mailing address used by the corporation or L.L.C. to receive mail by the U.S. Postal Service.

3. Identify the entity by checking corporation or L.L.C. Provide the employer's Federal Identification Number and the State Corporation Commission Number, if applicable.

4. Provide all requested information for the officer/manager terminating a prior rejection of coverage.

5. Signatures of the employer, officer/manager and the witness are required

Additional copies of this form are available without cost by writing to the Commission. Address requests to: "Forms," Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, Virginia 23220

(Name of Insured)
(Address)
(City, State, Zip Code)

VIRGINIA CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM (CCPAP) WORKERS COMPENSATION PREMIUM CREDIT APPLICATION

The Virginia Contracting Classification Premium Adjustment program is applicable to qualifying employers engaged in contracting operations and is applicable to policies with effective dates on or after January 1, 1997. In order to qualify for the program, more than 50% of your manual premium must be attributable to one or more contracting classifications (as designated in the program) and you must be experience rated.

A special premium calculation, which may result in a premium credit for you, will be based on hourly pay rates for each contracting classification. In order that your premium may be correctly established, please return the completed premium credit application, as set out on the reverse side of this letter, to:

National Council on Compensation Insurance, Inc.
Customer Service Center
901 Peninsula Corporate Circle
Boca Raton, Florida 33487-0998

NCCI will advise of any premium credit applicable.

If NCCI does not receive this application within 180 days after policy inception or receipt of notification, your premium calculation will not reflect any possible premium credit.

For each applicable classification (both contracting and noncontracting) covering your company's operations in the Commonwealth of Virginia, report the total Virginia payroll reported to the Virginia Employment Commission and the corresponding total number of hours worked, for the third calendar quarter (July, August, September) of the year preceding your anniversary rating date as reported to taxing authorities.

Note #1: If you did not engage in contracting operations during the third quarter, provide the requested information for the last complete calendar quarter prior to the anniversary rating date of your workers compensation policy.

Note #2: If you are a new business (no prior operations), submit the requested information for the first complete calendar quarter following the anniversary rating date of your workers compensation policy when available.

Note #3: In the absence of specific records for salaried employees, you should assume that each individual worked forty (40) hours per week. Payroll for partners, sole proprietors, and corporate officers subject to contracting classifications will be allocated according to appropriate ***Basic Manual*** minimums and maximums.

Note #4: In the absence of a specific anniversary rating date being supplied on the application, it will be assumed that the policy effective date is the same as the anniversary rating date.

You must preserve your anniversary rating date and payroll records that formed the basis for this declaration because we are required to verify the reported information in order to apply any premium credit.

Thank you for your cooperation.

Sincerely,

WORKERS COMPENSATION—PREMIUM CREDIT APPLICATION

INSURED _____

POLICY NO. _____ **POLICY EFFECTIVE DATE** _____ **ANNIVERSARY RATING DATE (as defined in NCCI's *Basic Manual*)** _____

CARRIER NAME: _____

Note: Unless code(s), total wages paid, total hours worked, and calendar quarter reported are indicated and application is signed, it cannot be processed. Contact your agent or carrier if assistance is desired.

Is this a new business? No ☐ Yes ☐

If no, submit information for the third calendar quarter (July, August, September) of the preceding calendar year as reported to taxing authorities.

If yes, submit information for the first complete calendar quarter following the effective date of your workers compensation policy.

The following is based on actual wages and hours worked, as reflected in our payroll records, for the complete calendar quarter ending _____.

"Contracting classifications" are those classifications subject to the following code numbers:

0042	5037	5190	5445	5508	6005	6233	7538
0050	5040	5213	5462	5535	6017	6235	7601
1322	5057	5215	5472	5537	6018	6236	7605
1605	5059	5221	5473	5551	6045	6237	7611
2799	5067	5222	5474	5606	6204	6251	7612
3365	5069	5223	5478	5610	6206	6252	7613
3719	5102	5348	5479	5645	6213	6260	7855
3724	5146	5402	5480	5651	6214	6306	8227
3726	5160	5403	5491	5703	6216	6319	9534
5020	5183	5437	5506	5705	6217	6325	9554
5022	5188	5443	5507	6003	6229	6400	

CLASSIFICATION	CODE	TOTAL VIRGINIA WAGES PAID*	TOTAL HOURS WORKED
Example: Electrical Wiring	5190	$8,000	520
Contracting Classifications:			

* For each classification code, combine all wages for that code in a single entry. Employee names are not required.

For each application classification (both contracting and noncontracting) covering your company's operations in the Commonwealth of Virginia, report the total Virginia payroll reported to the Virginia Employment Commission, as well as the entire pay for any exempt sole proprietor, partner, or officer, and the corresponding total number of hours worked, for the third calendar quarter (July, August, September) of the year preceding your anniversary rating date as reported to taxing authorities.

SIGNATURE: _____ **POSITION:** _____ **DATE:** _____

This application must be completed and signed or it will not be processed.

Form 45-3B

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.

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

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.

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