YOUR WORKERS' COMPENSATION POLICY GUIDE
District of Columbia

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

How to pay your bill
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
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 noncompliance 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**.

Subcontractors

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

Workers' Compensation

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

Subcontractor waivers are ***not*** accepted.

Your records

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

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

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

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

To view audit information en español, go to **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. 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: 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.

Notice of Election or Rejection of Workers' Compensation Coverage (WCADC4 3.09) - According to the District of Columbia Workers' Compensation Act sole proprietors and partners are excluded from coverage. Should a sole proprietor or partner wish to be included for coverage they should complete this form. Please note that Executive Officers and LLC members must be included for coverage and cannot elect to exclude themselves.

Claims Forms:
Employee's Notice of Accidental Injury or Occupational Disease (OWC-7)
Employee's Claim Application (OWC-7A)
Employer's First Report of Injury or Occupational Disease (OWC-8)

Other Forms:
Drug Policy
Drug Testing Acknowledgement
Workers' Compensation Experience Rating for Non-Affiliate Data (Form ERM-6)
Catastrophe (Other Than Certified Acts of Terrorism) Premium Endorsement
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement
Notice Of Election of Coverage Under Workers' Compensation Law
New Business Premium Allocation

NOTICE OF ELECTION OF COVERAGE
UNDER WORKERS' COMPENSATION LAW

TO: Builders Mutual Insurance Company

RE: _____
(Print Name of Owners or Partners)

doing business as _____
(Firm or Trade Name)

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

FEIN: _____

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

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

_____ _____
(Signature)

_____
(Name & Title)

_____ _____
(Signature)

_____
(Name & Title)

_____ _____
(Signature)

_____
(Name & Title)

_____ _____
(Signature)

_____
(Name & Title)

THE COVERAGE SHALL BE EFFECTIVE THIRTY DAYS AFTER RECEIPT.

Return completed form to:
Underwriting Department
Builders Mutual Insurance Company
Post Office Box 150005
Raleigh, NC 27624-0005

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKER'S COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011

(202) 576-6265

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

_____
Date of This Report

_____
Employee Social Security No.

_____
Employer Identification No.

_____
Insurer No.

EMPLOYEE'S
NOTICE OF ACCIDENTAL INJURY OR OCCUPATION DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYEE

YOU MUST FILE THIS REPORT WITHIN 30 DAYS AFTER YOU BECOME AWARE OF AN ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE AND ITS RELATIONSHIP TO YOUR JOB. PART 1 SHOULD BE MAILED TO THE D.C. GOVERNMENT, OFFICE OF WORKERS' COMPENSATION AT THE ABOVE ADDRESS. PART 2 SHOULD BE MAILED OR DELIVERED TO YOUR EMPLOYER, AND PART 3 RETAINED FOR YOUR RECORDS. IN ORDER TO PRESERVE YOUR RIGHTS UNDER THE LAW, YOU MUST FILE A CLAIM FORM NO. 7a DCWC, A COPY OF WHICH CAN BE OBTAINED FROM YOUR EMPLOYER OR THE OFFICE OF WORKERS' COMPENSATION.

Date and Time of Injury: _____ am/pm?

Place where injury occurred: _____

Description of Injury: _____

_____

THIS IS TO NOTIFY YOU _____
(Employer)

THAT I _____ while in your employ, sustained an injury ☐ or contracted an occupational disease ☐ as described above, caused by:

_____

Treating Physician's Name and Address: _____

_____

_____
(Employee's Signature)

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKER'S COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011

(202) 671-1000

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

_____
Date of This Report

_____
Employee Social Security No.

_____
Employer Identification No.

_____
Insurer No.

EMPLOYEE'S CLAIM APPLICATION

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYEE

A CLAIM FOR WORKERS' COMPENSATION BENEFITS HAS BEEN FILED WITH THIS OFFICE. YOU HAVE 14 DAYS FROM THE RECEIPT OF THIS NOTICE IF YOU HAVE NO PREVIOUS KNOWLEDGE OF INJURY OR ITS RELATIONSHIP TO EMPLOYMENT, TO BEGIN VOLUNTARY PAYMENTS OF WORKERS' COMPENSATION BENEFITS TO THE ABOVE NAMED EMPLOYEE, OR YOU MUST FILE A NOTICE OF CONTROVERSION, MEMO OF DENIAL OF BENEFITS, FORM NO. 11 DCWC WITH THIS OFFICE. FAILURE TO PAY BENEFITS, UNLESS YOU CONTROVERT THE EMPLOYEE'S RIGHT TO BENEFITS, WILL SUBJECT YOU TO PENALTIES UNDER THE ACT. YOU SHOULD CONTACT YOU INSURER IMMEDIATELY.

Date and Time of Injury: _____am/pm? Office Representative _____

Place where injury occurred: _____

Description of Injury: _____

_____

THIS IS TO NOTIFY YOU _____

That while in the employ of the above named employer I sustained a disabling injury ☐ or contracted an occupational disease ☐ as described above. The disability was caused by: _____

Treating Physician's Name and Address: _____

_____

YOU SHOULD HAVE ALREADY FILED OR SHOULD FILE EMPLOYEE'S NOTICE OF ACCIDENTIAL INJURY OR OCCUPATIONAL DISEASE, FORM NO. 7 DCWC.

I HAVE FILED THE CLAIM WITH THE OFFICE OF WORKERS' COMPENSATION.

FORM NO. 7A DCWC

_____
(Employee's Signature)

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKER'S COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011

(202) 671-1000

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

_____
Date of This Report

_____
Employee Social Security No.

_____
Employer Identification No.

_____
Insurer No.

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

IMPORTANT: Every employer shall file this report as soon as possible after knowledge of an occupational injury or disease to one of his employees, but no later than ten days thereafter. Failure to file this form shall be subject to a civil penalty not to exceed $1000.

Date and Time of Injury: _____am/pm? Day of Week?

Normal starting time _____ am / pm? If employee back to work, give date and time _____ am / pm?

At what wage? _____ If fatal, give date of death (file supplement report). _____

Date disability began? _____ am / pm? Was injured paid in full for this day? _____ . Was injured given Form No. 7 DCWC?

_____ Foreman_____

When did you or foreman first know of injury? _____ Male _____ Female _____ Age _____

Employee's telephone No. _____ Occupation when injured _____ was this his/her regular

occcupation? _____ (Deprt. or Branch where regularly employed) _____

Was injured party hired in DC? yes How long employed by you? 46yrs Piece or time worker? no Hourly wage? _____

Hours worked/day _____ Daily wages _____ Days worked per week _____ Average weekly earnings _____

If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week, or month: _____

Employer's principle business function in DC_____ Employers Tel. No. _____ Insurance Policy No.

_____

Location of plant or place where accident occurred: _____ on employer's premises? _____

Describe fully the events which resulted in injury or disease, what the employee was doing when injured and type of injury including parts of body affected:

_____

_____

Names of Witnesses _____

Nature and location of injury (describe fully): _____

_____

Attending Physician and Address (If Hospital Involved--Indicate):

_____

_____

_____
Name (Please Print or Type)

_____
Name of Person Completing Form

_____
Signature

_____
Official Position

FORM NO. 8 DCWC

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 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.

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 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