EXHIBIT 1c
UCIP INSURANCE MANUAL

SEE ATTACHED

The Regents of the University of California

University Controlled Insurance Program (UCIP)

UCIP Insurance Manual

UNIVERSITY CONTROLLED INSURANCE PROGRAM

Insurance Manual

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA
1111 Franklin Street, 10th Floor
Oakland, CA. 94607

Table of Contents

Section 1

1. Overview

Welcome to The Regents of the University of California's University Controlled Insurance Program.

The Regents of the University of California has arranged for this Project to be insured under the University Controlled Insurance Program, or "UCIP." The UCIP is a single insurance program that insures the University of California, Enrolled Contractors, Enrolled Subcontractors, and other designated parties for Work performed at the Project Site. Certain Contractors or Subcontractors are excluded from the UCIP. These parties are identified in Section 3 of this Manual.

Coverage under the UCIP includes Workers' Compensation/Employer's Liability, General Liability, and Excess Liability.

The University of California will pay the insurance premiums for the UCIP coverages described in this Insurance Manual. You should notify your insurance broker/insurer(s) of the coverages provided under the UCIP for on-site activities to avoid the duplication of coverage. **Each bidder is required to bid net of all insurance costs for coverages provided by the University of California.**

NOTE:

Insurance coverages and limits provided under the UCIP are limited in scope and are specific to work performed after the inception date of your enrollment into this program. Your insurance representative should review this information. **Any additional coverage you may wish to purchase will be at your option and expense.**

UCIP Definitions

The following definitions shall apply throughout this manual:

TERM	DEFINITION
BID NET OF COST OF UCIP COVERAGES:	A bid submitted by Contractor or Subcontractors to perform Work or a portion of the Work, which is net of the Contractor's or Subcontractors' Cost of UCIP Coverages.
CONTRACT:	The term "Contract" means the written Agreement between the Contractor and Owner as set forth in the Contract Documents.
CONTRACTOR:	The term "Contractor" means the person or firm identified as the Contractor, CM/Contractor, Design Builder, or Prime Trade Contractor in the Agreement, and is referred to throughout the Contract Documents as if singular in number.
COST OF UCIP COVERAGES:	Cost of UCIP Coverages shall mean Contractor's or Subcontractor's projected or actual cost to provide the workers' compensation and employer's liability, commercial general liability insurance, and excess liability insurance being provided under the UCIP. The Cost of UCIP Coverages includes insurance premiums, related taxes and assessments, markup on the insurance premiums, and losses retained through the use of a self-funded program, self-insured retention, or deductible program. The cost of insurance must include expected losses within any retained risk.
ELIGIBLE PARTIES:	See page 7.
ENROLLED PARTIES:	See page 7.
EXCLUDED PARTIES:	See page 7.
OWNER:	The Regents of the University of California, also referred to as the University of California
PROJECT:	The term "Project" means the Work of the Contract and all other work, labor, equipment, and materials necessary to accomplish the construction of the improvement of which the Work is a part.

SUBCONTRACTOR:	The term "Subcontractor" means a person or firm that has a contract with Contractor or with a Subcontractor to perform a portion of the Work. Unless otherwise specifically provided, the term Subcontractor includes Subcontractors of all tiers.
UCIP ADMINISTRATOR:	The entity hired by the University of California to administer the UCIP. The UCIP Administrator is: Aon Risk Insurance Services West, Inc. 199 Fremont Street, Suite 1500 San Francisco, California 94105
UCIP COVERAGES:	The insurance coverages provided under the UCIP, as set forth in the UCIP Policies, and as summarized in this Insurance Manual.
UCIP INSURER:	Any of the insurance companies providing insurance under the UCIP.
UCIP POLICIES:	The insurance policies issued by a UCIP Insurer for the UCIP.
UCIP:	The University of California's University Controlled Insurance Program.
WORK:	The term "Work" means all construction, services, and other requirements of the Contract Documents as modified by Change Order, whether completed or partially completed, and includes all labor, materials, equipment, tools, and services provided or to be provided by Contractor to fulfill Contractor's obligations. The Work will constitute a part of the Project.

Enrollment in the UCIP is mandatory for all Eligible Parties. **In addition to the insurance provided under the UCIP,** Enrolled Parties shall obtain and maintain, and shall require each of their Subcontractors of all tiers to obtain and maintain, the insurance coverage specified in Section 4. Excluded Parties and parties no longer enrolled in, or covered by, the UCIP shall obtain and maintain, and require each of their Subcontractors to obtain and maintain, the insurance coverage specified in Section 4.

About This Manual

This Insurance Manual has been prepared by Aon, the UCIP Administrator, and the University. The Insurance Manual is designed to provide an overview of the UCIP and identify, define and assign responsibilities for the administration of the UCIP.

This Insurance Manual may be updated as necessary during the course of construction to reflect any changes in State Rules and/or Regulation or Procedures that may become applicable. Said revisions shall replace all previous versions. Copies of any revised Insurance Manual shall be distributed by the UCIP Administrator.

What This Manual Does

This Manual:

- Sets forth the responsibilities of the various parties involved in the Project, including the insurance-related obligations of Contractors and Subcontractors, whether or not enrolled in the UCIP
- Describes the general structure of the UCIP
- Provides a *basic* description of UCIP coverages
- Describes audit and administrative procedures
- Provides answers to basic questions about the UCIP

What this Manual Does Not Do

This Manual does not:

- Provide complete information about coverages
- Amend, modify or change the policy
- Provide coverage interpretations or answer specific claims questions

Refer questions concerning the UCIP, its administration, insurance coverages, or claims to the appropriate party identified in the Project Directory. The Directory immediately follows this introduction.

DISCLAIMER:

The information in this Manual is intended to outline the UCIP Program. If any conflict exists between this Manual and the UCIP insurance policies or Contracts between the University of California and the Contractor or their Subcontractors, the insurance policies or Contracts will govern.

Section 2

2. UCIP Project Directory

The following list includes key personnel involved in the program

UCIP Administrator

Aon Risk Insurance Services West, Inc.
199 Fremont Street, 17th Floor
San Francisco, CA. 94105

Phone: (415) 486-7500
Fax: (415) 486-7022

Sr. Program Administrator
Scott Brama

Phone: (415) 486-7566
Email: scott.brama@aon.com

Program Manager
Josh Schultz

Phone: (415) 486-7238
Email: josh.schultz@aon.com

Regional Safety Director
Scott Maxey

Phone: (213) 996-1545
Email: scott.maxey@aon.com

Project Safety Consultant
TBD

Phone: TBD
Email: TBD

General Contractor / Construction Manager

TBD
TBD
TBD

Phone: TBD
Fax: TBD

Contracts Manager/Administrator
TBD

Phone: TBD
Email: TBD

Project Manager
TBD

Phone: TBD
Email: TBD

Project Superintendent
TBD

Phone: TBD
Email: TBD

Project Safety Manager
TBD

Phone: TBD
Email: TBD

University

The University of California –
TBD
TBD

Project Manager TBD	**Phone:** **Email:**	TBD TBD
Contracts Manager/Administrator TBD	**Phone:** **Email:**	TBD TBD
Director of Risk Management – Campus TBD	**Phone:** **Email:**	TBD TBD
Insurance Programs Manager – OP Cindy Low	**Phone:** **Email:**	(510) 987-9828 cynthia.low@ucop.edu
Director of Risk Management – OP Grace Crickette	**Phone:** **Email:**	(510) 987-9820 grace.crickette@ucop.edu

UCIP Insurer

Zurich in North America
560 Mission Street, Suite 2300
San Francisco, CA 94105

Regional Safety Manager Doug Stohlman	**Phone:** **Email:**	(916) 765-1507 doug.stohlman@zurichna.com
Adjuster WC – Medical Only Marilyn Carpenter	**Phone:** **Email:**	(916) 636-0789 marilyn.carpenter@zurichna.com
Lost Time Examiner – Tier II Terry Woodcock	**Phone:** **Email:**	(916) 636-8600 terri.woodcock@zurichna.com
Lost Time WC Handler – Tier III Edmond "Eddie" Sedigh	**Phone:** **Email:**	(818) 227-1797 edmond.sedigh@zurichna.com
WC Team Manager Michelle Abram-Hogan	**Phone:** **Email:**	(818) 227-1781 michell.abram-hogan@zurichna.com

Section 3

3. UCIP Insurance Coverage

This section provides a brief description of UCIP Coverages. You must refer to the actual policies for details concerning coverage, exclusions and limitations.

Eligible Parties

Unless excluded (see below), each of the following who will perform any labor at the Project site (labor may be performed either by the party or by a Subcontractor to a party) are an "Eligible Party:" Contractor, all Subcontractors of all tiers, and such other persons or entities as University may designate, in its sole discretion.

Enrolled Parties

Enrolled Parties are named insureds on the UCIP policies. Enrolled Parties include:

- The University of California, and The University of California's Representative;
- A Contractor that is eligible for and enrolls in the UCIP;
- Subcontractors who are eligible for, and enroll in the UCIP,
- Any other Eligible Party that enrolls in the UCIP.

Parties named as additional insureds include other parties that the University of California is required under contract to add as additional insureds. These parties are also referred to as insureds.

Excluded Parties

"Excluded Parties" are:

1. Heavy and/or structural demolition, hazardous materials remediation, removal and/or transport companies and their consultants;

2. Architects, surveyors, engineers, and soil testing engineers, and their consultants (except for architects, surveyors, engineers and soil testing engineers that are employees of Contractor or Subcontractor).

3. Vendors, suppliers, fabricators, material dealers, truckers, haulers, drivers, common carriers and others who do not perform work at the Project site or who merely transport, pick up, deliver, or carry materials, personnel, parts or equipment, or any other items or persons to or from the Project site;

4. Subcontractors of all tiers that do not perform any actual labor on the Project site with their own forces or through a Subcontractor;

5. Temporary labor services;

6. Persons or Entities who are not an Eligible Party who are enrolled in the UCIP; and

7. Any other person or entity that the University, acting in its sole discretion, elects to exclude, even if otherwise eligible.

Excluded Parties are not eligible to enroll in the UCIP. The UCIP does not provide any coverage to an Excluded Party. All Excluded Parties, and any party no longer enrolled in, or covered by, the UCIP shall obtain and maintain, and shall require each of their subcontractors of any tier to obtain and maintain, the insurance coverage specified in Section 4.

Evidence of Coverage

The UCIP Administrator will provide upon enrollment a Certificate of Insurance evidencing workers' compensation, general liability, and excess liability coverage to each Enrolled Party, each of whom will then be a named insured on the UCIP policies. A ***Certificate of Insurance*** is a document providing evidence of coverage for a particular insurance policy or policies. Other documentation including claim reporting forms, posting notices, etc., will be furnished to each Enrolled Party.

Each Contractor will receive a copy of the workers' compensation policy, and copies of the remaining UCIP insurance policies will be available for your review upon a written request to the UCIP Administrator.

Summary Description of UCIP Coverages

This summary is not an insurance policy and is not intended to amend, alter, or extend the coverage afforded by the UCIP Policies. The coverage provided under the UCIP Policies is governed by the terms, conditions, exclusions, and limitations of the UCIP Policies. The following descriptions provide a summary of the insurance coverages provided under the UCIP:

Workers' Compensation and Employers Liability

State: California

		LIMITS OF LIABILITY
Part One -	Workers' Compensation:	Statutory
Part Two -	Employer's Liability:	
	Bodily Injury by Accident, each accident	$2,000,000
	Bodily Injury by Disease, each employee	$2,000,000
	Bodily Injury by Disease, policy limit	$2,000,000

A single General Liability Policy will be issued covering all insureds.

Commercial General Liability

	Per Project Limits Shared by All Insureds
General Aggregate	$4,000,000
Products/Completed Operations Aggregate	$4,000,000
Bodily Injury & Property Damage–Each Occurrence	$2,000,000
Personal/Advertising Injury–Each Occurrence	$2,000,000
Fire Damage Legal Liability	$1,000,000
Medical Expense	$5,000

Contractor and Subcontractors of all Tiers Will Be Responsible for a General Liability Obligation Per Occurrence for any Claim Due To CM/Contractor or Subcontractor's Negligence as Shown In Its Contract Language For Any Third Party Damages/Injuries Caused By The CM/Contractor Or Its Subcontractors. The Specific Amount of This Obligation Is Based On Contract Value.

- Products & Completed Operations Extension is 10 Years
- This insurance will **NOT** provide coverage for products liability to any insured party, vendor, supplier, off-site fabricator, material dealer or other party for any product manufactured, assembled or otherwise worked upon away from the Project Site.
- **The policy contains exclusions.** Some of these exclusions are: Real & Personal Property in the care, custody or control of the insured; Asbestos; Lead; EFIS; Discrimination & Wrongful Termination; ERISA; Architects & Engineers Errors & Omissions; Owned & Non-Owned Aircraft, Watercraft, Pollution and Automobile Liability; Nuclear Broad Form Liability, and other exclusions referred to in Exhibit 1A, the UCIP Coverage Summary.

Excess Umbrella Liability

	Per Project Limits Shared by All Insureds
Each Occurrence Limit	$100,000,000
Annual General Aggregate Limit	$100,000,000

- The Policies follow form (provisions, coverage, exclusions, etc.) of underlying Commercial General Liability and Employer's Liability policy wording.
- University of California reserves the right to supply additional limits upon final review.

Contractor Obligation

In the event of a Commercial General Liability loss covered by the UCIP, Contractor shall pay to the University an amount as set forth below. Payment pursuant to the preceding sentence shall not in any way limit the liability of Contractor to University or otherwise. The amount to be paid, which is based on the Contract Sum of the Contractor's Contract at the time of the loss is reported, is as follows:

Contract Sum	Amount to be Paid
$1,000,000 or Less	$1,000
$1,000,001 to $10,000,000	$5,000
$10,000,001 and Over	$25,000

NOTE:

Insurance coverage and limits described in this Section are limited in scope and are specific to Work performed at the Project Site and after the inception date of your enrollment into this Program. Your insurance representative should review this information. **Any additional coverage you may wish to purchase will be at your option and expense.**

Coverage of Off-site Locations

Work (as defined in the General Conditions) that is performed at a fully project dedicated off site location, which is not specified in the General Conditions, can, at the University's sole discretion, be treated as on site Work provided that at the time of enrollment in the UCIP the off site location is identified to the UCIP Administrator and scheduled on the UCIP policies. Contact the UCIP Administrator in order to schedule an off site location with the UCIP; allow thirty (30) days to schedule the off site location on the UCIP policies.

NOTE:

Contractor and Subcontractors are advised to arrange their own insurance for Contractor or Subcontractors owned or leased equipment and materials not intended for inclusion in the Project. The UCIP will not cover Contractor or Subcontractor's property.

UCIP Termination or Modification

University may, for any reason, modify the UCIP Coverages, discontinue the UCIP, or request that Contractor or any of its Subcontractors of any tier withdraw from the UCIP upon thirty (30) days written notice. Upon such notice Contractor and/or one or more of its Subcontractors, as specified by University in such notice, shall obtain and thereafter maintain during the performance of the Work, all (or a portion thereof as specified by University) of the UCIP Coverages. The form, content, limits of liability, cost, and the insurer issuing such replacement insurance shall be subject to University's approval. The University shall pay Contractor for the reasonable cost of replacement coverage approved by the University.

Section 4

4. Insurance Required From All Contractors and Subcontractors, Including Excluded Parties

Enrolled Contractor and Enrolled Subcontractors are required to maintain insurance coverages to protect against losses that occur away from the Project Site or that are otherwise not insured by the UCIP.

Contractors and Subcontractors are required to maintain insurance coverage that protects the University of California from liability for claims for damages. These liabilities may arise from the Contractor's and Subcontractors' operations performed off the Project Site at locations that have not been disclosed to the UCIP Administrator and scheduled on the UCIP policies, from activities not insured by the UCIP or from operations performed by Excluded Parties. There are two types of Contractors and Subcontractors: Enrolled Contractors and Subcontractors and Excluded Contractors and Subcontractors.

See Section 7 for sample Certificate of Insurance.

Enrolled Contractor and Subcontractors are to provide evidence of Workers' Compensation and General Liability Insurance for *off-site activities* and Automobile Liability Insurance for both *on-site and off-site activities* via a Certificate(s) of Insurance with additional insured endorsements as per the insurance specifications in the Contract.

Excluded Subcontractors must provide evidence of Workers' Compensation, General Liability, Auto Liability Insurance, and for other insurance as required by scope of work (i.e. Hazardous Remediation Pollution Liability), if any, for all activities including **both** *on-site* and *off-site* activities via a Certificate(s) of Insurance with additional insured endorsements as per the insurance specifications in the Contract.

Subcontractors must submit verification of insurance in the form of a Certificate of Insurance on a standard ACORD 25 form. They must provide a Certificate of

Insurance to the UCIP Administrator prior to mobilization on site, and within ten (10) days of any renewal, change or replacement of coverage. A sample of an acceptable Certificate of Insurance is provided in Section 7.

Contractor must provide a certificate of insurance providing a notice of cancellation clause in accordance with the policy provisions. The additional insured endorsements shall state that the coverage provided to the additional insureds is primary and non-contributing with respect to any other insurance available to the additional insureds.

Certificate of Insurance

- 5 days prior to mobilization and within ten (10) days of renewal, change or replacement of coverage, Contractor and Subcontractor will submit to the University of California a Certificate of Insurance evidencing the coverage and limits as specified in this section.
- A notice of cancellation provision, waiver of subrogation and additional insured status is required on all Certificates.

Pursuant to the Instructions to Bidders, Contractor shall provide its certificates of insurance to University within 10 days after receipt of notice of selection as the apparent lowest responsive and responsible Bidder. All other parties shall provide, prior to mobilization, their certificates of insurance directly to the UCIP Administrator.

The limits of liability shown for the insurance required of the Contractor and Subcontractors are minimum limits only and do not restrict the liability imposed on the Contractor and Subcontractors for Work performed under their Contract. Limits required below can be provided by a combination of primary and umbrella/excess liability insurance. If umbrella/excess liability coverages are to be provided, such policies shall be follow form (provisions, coverage, exclusions, etc.) of underlying Commercial General Liability, Employer's Liability and Automobile Liability policy wording.

Workers' Compensation and Employer's Liability

Part One - Workers' Compensation:	**Statutory Limit**
Part Two - Employer's Liability:	**Annual Limits**
Bodily Injury by Accident, each accident	$1,000,000
Bodily Injury by Disease, each employee	$1,000,000
Bodily Injury by Disease, policy limit	$1,000,000

- Eligible Contractors shall provide evidence of workers' compensation insurance for off-site activities.

Excluded
Contractors shall provide evidence of workers' compensation applicable to on and off-site project.

Commercial General Liability/Umbrella Liability

	Limits of Liability Enrolled / Excluded
General Aggregate	$2,000,000 / $4,000,000
Products/Completed Operations Aggregate	$2,000,000 / $4,000,000

Eligible
Contractors shall provide evidence of general liability insurance for off-site activities.

Excluded
Contractors shall provide evidence of general liability insurance applicable to on and off-site projects and must add the University of California and other parties as additional insureds to their policy.

Automobile Liability
Contractor and Subcontractors shall provide evidence of automobile liability. The UCIP does not cover automobile liability.

Personal/Advertising Injury Aggregate	$1,000,000 / $2,000,000
Each Occurrence Limit	$2,000,000 / $2,000,000

Coverage must be on an Occurrence Form and it must apply to bodily injury and property damage for operations (including explosion, collapse and underground coverage), independent Contractor or Subcontractor, products and completed operations.

Automobile Liability

A Commercial Business Auto Policy which covers all owned, hired and non-owned automobiles, trucks and trailers with coverage limits not less than **$1,000,000. This can be a combination of the Automobile Liability and Excess Policy,** each accident for bodily injury and property damage on-site and off-site.

Property Insurance

Contractor and Subcontractors are advised to arrange their own insurance for owned and leased equipment (not to be permanently installed or incorporated into the Project), whether such equipment is located at a Project Site or "in transit". Contractor and Subcontractors are solely responsible for any loss or damage to their personal property including Contractor and Subcontractor tools and equipment, temporary structures (including construction trailers), whether owned, used, leased or rented by the Contractor and Subcontractor. Contractor and Subcontractors are also responsible for any loss or damage to property or materials created or provided under the Contract until the property or materials arrives at the Project Site.

Additional Insureds

With exception to Workers' Compensation and Employer's Liability insurance, the following shall be included as additional insureds as required by contract: The University of California, its officers, employees, related entities, representatives and Authorized Representatives. Refer to the sample Certificate of Insurance provided with this Insurance Manual. The list of additional insureds may be updated at any time due to contractual requirements of the University of California.

Waiver of Subrogation

Contractor and Subcontractors of all tiers waive subrogation as set forth in Section 11.1.13 of the General Conditions.

Section 5

5. Contractor and Subcontractor Responsibilities

Throughout the course of the Project, Contractor and Subcontractors will be responsible for reporting and maintaining certain records as outlined in this section. Additionally, Subcontractors will be required to provide a completed Declaration of Contractor or Subcontractor Minimum Occupational Safety and Health Qualifications prior to commencement of Work by the Subcontractor.

The Contractor and Subcontractors are required to cooperate with the University of California and its UCIP Administrator in all aspects of UCIP implementation and administration. Responsibilities include the following:

- Contractor and all Subcontractors must enroll in the UCIP, if eligible, prior to mobilization. Prime Contractor has the responsibility to ensure that all eligible Subcontractors are enrolled prior to the Subcontractor's commencement of Work.
- Contractor and Subcontractors must provide copies of their current Workers' Compensation, General Liability and Excess Liability rate and declaration pages, deductible endorsements and any other required documentation. See **Adjustments for UCIP Insurance Costs**.
- Contractor and Subcontractors must provide timely evidence of required insurance to the UCIP Administrator, prior to mobilization and upon renewal, modification or material change of insurance.
- Contractor and Subcontractors must include UCIP provisions in all contracts with Subcontractors.
- Contractor must provide each Subcontractor with a copy of the UCIP Insurance Manual. The UCIP Insurance Manual may be updated during the course of construction to reflect any changes in state rules and/or regulations or procedures that may be necessary, and said revisions shall replace all previous versions. Copies of any revised Insurance Manual shall be distributed by the UCIP Administrator.
- Contractor must notify the UCIP Administrator of all subcontracts, including lower tier subcontracts.

- Contractor and Subcontractors must maintain and electronically report monthly payroll records.
- Contractor and Subcontractors must cooperate with the UCIP Administrator's requests for information.
- Contractor shall be responsible for monitoring and ensuring that its Subcontractors of all tiers comply with the requirement for providing Certificates of Insurance.
- Contractor and Subcontractors must notify the UCIP Administrator immediately of any insurance cancellation, modification, material change or non-renewal of required insurance.
- Subcontractors are required to provide work status reports to the Contractor following an injury sustained at the Project Site.
- Provide Medical Provider Network (MPN) packet to all employees working at the project site. See Section 6 for more information.

Declaration of Minimum Occupational Safety & Health Qualifications

Prior to commencement of Work by a Subcontractor, the Subcontractor must provide to the UCIP Administrator the completed *Declaration of Contractor or Subcontractor Minimum Occupational Safety and Health Qualifications* form demonstrating that the Subcontractor meets the following minimum occupational safety and health qualifications:

A. The Subcontractor must have had no serious and willful violations of Part 1 (commencing with Section 6300) of Division 5 of the Labor Code during the five-year period prior to bid opening.

B. The Subcontractor must have maintained a Workers' Compensation Experience Modification Rate (EMR) that averages below 1.15 for the past five years. (If Subcontractor has been in business for less than five years, then Subcontractor must have maintained a Workers' Compensation Experience Modification Rate (EMR) that averages below 1.15 for all years Subcontractor has been in business.)

C. The Subcontractor must have instituted an injury prevention program pursuant to Section 3201.5 or 6401.7 of the Labor Code.

A Subcontractor will not be allowed to Work on the Project until it submits the completed *Declaration of Contractor or Subcontractor Minimum Occupational Safety and Health Qualifications* form.

Contractor and Subcontractor Bids

See Section 7 for forms that can help identify your insurance costs.
See Section 2 for information on contacting the UCIP Administrator.

The University of California shall pay all premiums for the UCIP. Each Bidder is required to submit bids for the Project that are net of Contractor's and Subcontractors' Cost of UCIP Coverages. The section below, "Adjustments for UCIP Insurance Costs," describes the procedure for identifying the Costs of UCIP Coverages when bidding so these costs can be removed from the bid price. Section 7 of this Insurance Manual contains worksheets that can be used to estimate your insurance costs, and those of your Subcontractors, for the coverages provided under the UCIP.

Adjustments for UCIP Insurance Costs

Each Eligible Contractor and Subcontractor is required to ***exclude*** from their bid the cost of the insurance that is provided under the UCIP.

To aid the Contractor and its Subcontractors in determining the cost of insurance to remove from the bid, the Insurance Cost Worksheet form (Aon Form-1a) and Insurance Cost Summary form (Aon Form-2) are provided in Section 7. A separate Aon Form-1a is required from the Contractor and each Subcontractor.

Each Enrolled Contractor and Enrolled Subcontractor will be required to submit the insurance documentation listed below. Documentation will include the following pages from the Workers' Compensation, General Liability and Excess Liability policies:

- Declarations or information page
- Rate page(s) – rates must reflect first dollar coverage; no composite rates or corporate allocations based on deductible/retention programs
- Deductible endorsements, if applicable
- Verification of experience modification (Workers' Compensation only)
- 3 Years of loss history from the insurance carrier, and including self-paid losses, for entities that retain losses through deductible, self-insured, or high retention programs in the amount of $5,000 or more.

Change Orders

Change orders will be priced by the Enrolled Contractor and Subcontractors to **exclude** the cost of insurance provided under the UCIP.

Contractor and Subcontractors are responsible for ensuring that their Subcontractors of all tiers also remove the Cost of UCIP Coverages from their Bid and Change Orders.

UCIP Administrator will assist the Contractor and Subcontractors in verification of Subcontractors' insurance reduction calculations.

Enrollment

See Section 7 for sample UCIP forms.

Enrolled Contractor shall provide details about its Subcontractors to the UCIP Administrator in order to enroll them in the UCIP. The Contractor and Subcontractors must complete and submit the Enrollment Application (Aon Form-3). This form can be found in Section 7. The Enrollment Application must be completed and submitted to the UCIP Administrator and accepted prior to commencing work On Site to obtain coverage under the UCIP.

Enrolled Contractor and enrolled Subcontractors will receive a Confirmation Letter and UCIP Certificate of Insurance. A ***Confirmation Letter*** is a letter issued by the UCIP Administrator that confirms acceptance of the applicant into the UCIP. These documents will clearly identify the effective dates of the UCIP coverages for the Contract. A separate Workers' Compensation policy will be issued and sent to each enrolled Contractor and Subcontractor. A Claims Kit will be provided to each Enrolled Contractor and Subcontractors with the Confirmation Letter.

Should an enrolled Contractor or Subcontractor perform work under several Contracts, an Enrollment Application must be completed for each contract. A separate Confirmation Letter and Certificate of Insurance confirming acceptance of the applicant's enrollment into the UCIP will be issued for each Contract.

NOTE:

Enrollment into the UCIP is required, but ***not*** automatic. All Eligible Contractors and all Eligible Subcontractors MUST complete the enrollment forms and participate in the enrollment process to obtain UCIP coverage. Access to the Project Site will not be permitted until Enrollment into the UCIP is complete.

Coverage of Off-site Locations

Safety Standards establish minimum standards for Contractor safety programs. Safety Standards are provided to all participants during the bidding process.

Work (as defined in the General Conditions) that is performed at a fully project dedicated off site location, which is not specified in the General Conditions, can, at the University's sole discretion, be treated as on site Work provided that at the time of enrollment in the UCIP the off site location is identified to the UCIP Administrator and scheduled on the UCIP policies. Contact the UCIP Administrator in order to schedule an off site location with the UCIP; allow thirty (30) days to schedule the off site location on the UCIP policies.

Safety Standards

Each Contractor and Subcontractor is required to have a written safety program and to provide a designated safety representative who is on site when any Work is in progress. Minimum standards for Contractor and Subcontractor safety programs are outlined in the University of California's Safety Standards Manual.

A Drug Test Program has been implemented for this project for "post accident" and "for probable cause." The financial burden associated with these tests will be the responsibility of the employer of the affected worker(s).

The designated occupational clinic for the UCIP projects will administer the drug test at their facility. Please see the clinic address in the Claims Section.

An employer representative will transport all injured workers (**for non-emergency cases ONLY**) to the designated occupational clinic facility for treatment.

Please see the contract documents or Contractor's Drug Test Program for more details.

Payroll Reports

Enrolled Parties must submit monthly payroll reports to the UCIP Administrator identifying man-hours and payroll for all work performed at the Project Site by Contract and by Workers' Compensation Classification Codes.

Enrolled Parties shall submit payroll reports prior to the 10th of the following month through the online AonWrap Web Portal. Contact the UCIP Administrator for a User ID and Password to report payroll online if you do not receive this information during the Enrollment process. The monthly man-hour and payroll reports should include supervisory and clerical personnel on-site and cover all Work performed at or emanating directly from the Project Site.

Payroll for overtime should be included only at the normal hourly rate **(DO NOT INCLUDE EXTRA WAGES OR PREMIUM PORTION OF OVERTIME PAY WHEN CALCULATING ONSITE REPORTABLE PAYROLL)**. Overtime means those hours in excess of 8 hours worked each day, 40 hours in any week or on Saturdays, Sundays, or holidays, but only when there is an increase in the hourly rate to work such hours.

Insurance Company Payroll Audit

Each Enrolled Party is required to maintain payroll records for each Contract. Such records will allocate the payroll by Workers' Compensation classification(s) and exclude the excess or premium paid for overtime (i.e., only the straight time wage rate will apply to overtime hours worked). Furthermore, such records will limit the payroll for

Executive Officers and Partners/Sole Proprietors to the limitations as stated in the state manual rules.

It is important that you properly classify payrolls, as these are reported to the rating bureau for promulgation of future Experience Modification Ratings for your firm. All Enrolled Parties shall make available their books, vouchers, contracts, documents, and records, of any and all kinds, to the UCIP insurance carrier(s) auditors or the University's representatives. Availability of records must be for a reasonable time during the policy period, any extension, or during a final audit period as required by the insurance policies.

Close Out Procedures

Enrolled Parties must submit the Notice of Work Completion form (Aon Form-5) when all Work at the Project Site is complete and they no longer have workers on site. The completed Notice of Work Completion form will signal the final payroll report and initiate the audit of payroll by the UCIP Insurer. A copy of the Notice of Work Completion form with instructions on the proper method for completion is found in Section 7.

Failure to fill out the Notice of Work Completion and report all Payrolls in a timely manner may result in the University of California withholding issuance of final payment and release of retention pursuant to Article 9 of the General Conditions.

Section 6

6. Claim Reporting Procedures

This section describes basic procedures for reporting various types of claims including Workers' Compensation, liability, and damage to the project.

General Procedures

All Parties involved with the Project shall report all injuries, occupational-related illnesses, or property damage to the Safety Manager immediately. Contractor, Subcontractors, and any other party involved with the Project will instruct employees and other personnel to report, in writing, within 24 hours ***all*** accidents and occurrences resulting in bodily injury or property damage to the Safety Manager.

GC/CM Safety Manager:	**TBD**
Cell Phone:	TBD
E-mail:	TBD
UCIP Safety Manager:	**TBD**
Cell Phone:	TBD
Email:	TBD

Media Inquiries

Make no statements to the media. Refer all questions from the media to the Communications Office at the University of California location where the project is located.

Investigation Assistance

Contractor and all Subcontractors will report the claim promptly and assist in the investigation of any accident or occurrence involving injury to persons or damage to property. Contractor and all Subcontractors will cooperate with the companies involved

in adjusting any claim by securing and giving evidence and obtaining the participation and attendance of witnesses required for the investigation and defense of any claim or suit.

Workers' Compensation Claims

Claims Kits will be available to all Contractors. It will include details about claim reporting and is intended for use at the Project Site.

The main responsibility for all Parties is to first see that the injured worker receives immediate medical care. The designated medical facilities for Enrolled Party employees injured on this Project are:

Non-Emergency Injuries	Emergency & After Hours Injuries
TBD Occupational Health Clinic	**TBD Hospital**
Street	Street
XXX, CA TBD	XXX, CA TBD
Phone: XXX-XXX-XXXX Hours: 8:00 a.m. to 5:00 p.m. M – F Closed Weekends & Holidays	Phone: XXX-XXX-XXXX 24 Hours & Emergency Services

Driving directions to the facilities listed above are included in Section 7. Injuries occurring after hours or on weekends and holidays will be treated at the designated hospital listed above. For emergency treatment, the paramedics will determine the best emergency facility available for treatment.

All Parties involved with the Project shall report all injuries or occupational-related illnesses to the Safety Manager as soon as possible. Enrolled Party personnel will follow these procedures if an employee sustains bodily injury or an occupational-related illness while working at the Project Site:

Claims Monitoring
CM/Contractor will participate in monitoring Workers Compensation claims for Subcontractors.

1. Injured Workers should report to the Contractor job-site offices for injury assessment. Where medical treatment is required beyond the scope of First-Aid that can be administered on-site, the injured Worker will be referred to the designated Occupational Health Clinic or Hospital. The injured worker or accompanying supervisor should secure a **Treatment Authorization Form** from Contractor if they do not already have this form.

2. Contact the designated medical facility to advise them that an injured Worker will be arriving. Present the **Treatment Authorization Form** found in Section 7 of this manual to the clinic or hospital upon registration to identify the injured Worker as a UCIP participant working at a UCIP Project site.

   Contractor and Subcontractors must designate a representative at the site to

escort an injured Worker to the medical facility. This individual is to remain with the injured employee at the medical facility while he/she is being treated. The treating physician will provide a **Work Status Form** stating whether or not the injured employee can return to work, a list of restrictions, if any, and the estimated length of time the injured worker must be on modified duty.

Copies of the Work Status Form should be provided to the Employee, Employer, and the Contractor Safety Manager. If the **Work Status Form** is not submitted to the Contractor, the Contractor will request a copy from the injured Worker's employer.

3. As soon as possible, and within 24 hours of notice of injury sustained at the Project Site, the employer of an injured worker shall do the following:

   - Provide employee Workers' Compensation Claim Form (DWC-1)
   - Conduct a **Supervisor's Accident Investigation**
   - Fill out Employee and Employer sections of the DWC-1 and send it in to the insurance company when filing the claim
   - Prepare the Employer's Report of Occupational Injury or Illness (Form 5020)
   - **Report the Claim in one of the following ways:**

Call Zurich at:	**1-800-987-3373**
Fax Zurich at:	**1-877-962-2567**
Email Zurich at:	**USZ_CareCenter@Zurichna.com**
Upload via Website at:	**www.zurichna.com** **Click on 'Claims'** **Under 'Report a Claim'** **Click on 'ZNA Online Claims'**

When an employer reports the claim through one of the above methods, Zurich, the UCIP insurance company, will fill out the Employer's Report of Occupational Injury or Illness (Form 5020) and send a completed copy to the State and back to the employer. This satisfies the employer's requirement to provide the Report of Injury to the State Industrial Relations Division. The UCIP Insurance Company will also send a Claims Acknowledgement to the reporting employer with the assigned Claim Number and the Claim Adjuster contact information, as it becomes available.

4. Cooperate with the Claims Adjuster and keep Contractor informed of the

current Work Status of the injured Worker.

Drug Test Program

A Drug Test Program has been implemented for this project for "post accident" and "for probable cause." The provisions of the Drug Test Program will meet or exceed the Contractor's corporate program. The financial burden associated with these tests will be the responsibility of the employer of the affected worker(s).

Modified Duty / Early Return to Work Policy

The University of California has implemented a Modified Duty/Early Return to Work program. The purpose of this program is to keep injured workers gainfully employed during recovery. Modified duty benefits the injured worker as well as the contractor.

This policy establishes basic guidelines for an Early Return to Work (transitional duty) work assignment for injured workers. Each Employer shall have a written Early Return to Work Program that shall be implemented on this project unless specifically prohibited by the terms of a Collective Bargaining Agreement. Please see the UCIP Safety Standards Manual, page 27, for more information relating to Early Return to Work.

Contractor or Subcontractors are responsible for notifying the Occupational Safety and Health Administration (Cal-OSHA) when one or more of their employees are seriously injured.

A detailed incident report must be completed and turned in to the UCIP Safety Manager and Contractor's Safety Manager within twenty-four (24) hours of the accident/incident. The Employer will forward any additional documentation to the insurance carrier and to the UCIP Administrator.

Each Employer will be required to attend all claims meetings and participate in the management of claims for their employees.

When additional information is requested by the insurance carrier, the Employer is required to cooperate with the assigned claims adjuster.

Medical Provider Network (MPN)

Contractor and Subcontractors working on a UCIP Project will utilize the Medical Provider Network (MPN) program for industrial injuries. This program is a benefit

to the employer as it allows for more effective medical control for the life of the claim and may reduce many of the Workers' Compensation costs associated with each claim. The MPN contains an extensive number of occupational medicine facilities and other medical providers from which the injured worker is obligated by law to select if (1) the employer (Contractor/Subcontractor) has properly fulfilled its responsibilities and (2) the injured worker has not pre-designated his own personal physician.

MPN packets will be distributed to all enrolled participants by the UCIP Administrator at the time of their enrollment approval. These packets must be distributed to all employees who will work at the Project Site. The Contractor will also include the notification packets in their safety orientation to all employees attending the orientation.

Liability Claims

Report all Liability claims to the UCIP Administrator.

Incidents or accidents at or around the Project Site, or at a designated off-site location that has been added to the UCIP policies (see definition of *Project Site* on page 2), resulting in damage to property of others (other than your own work product), or personal injury or death to a member of the public, must be reported immediately to the designated Project and Safety Managers. Follows these Procedures in the event of such and incident or accident:

1. Take appropriate emergency measures to prevent additional injury or damage, including contacting the police or fire authorities, as required by law.

Claims Monitoring
CM/Contractor will participate in monitoring Workers Compensation claims for Subcontractors.

2. Report the incident and all subsequent inquiries or correspondence about an insured loss or claim, including a summons or other legal documents, to the Safety Manager.

3. **Report the Claim in one of the following ways:**

Call Zurich at:	**1-800-987-3373**
Fax Zurich at:	**1-877-962-2567**
Email Zurich at:	**USZ_CareCenter@Zurichna.com**
Upload via Website at:	**www.zurichna.com** **Click on 'Claims'** **Under 'Report a Claim'** **Click on 'ZNA Online Claims'**

Automobile Claims

No insurance coverage is provided for automobile accidents under the UCIP. It is the sole responsibility of Contractor and Subcontractors to report accidents/claims involving their automobiles to their own insurers.

Report all Auto claims to your insurance carrier and the UCIP Administrator.

However, all accidents occurring in or around the Project Site must be reported to the designated Project and Safety Representatives. (See Section 2 for contact information). The accident will be investigated to determine any liability arising out of the project construction activities that could result in future claims (i.e., due to the conditions of the roads, etc.). Contractor and Subcontractors shall cooperate in the investigation of all automobile accidents.

Section 7

7. Forms

This section contains the forms needed for enrolling into the UCIP, reporting payroll and overall administration of the UCIP.

This section contains the following forms:

Notice of Subcontract Award

Aon Form-1 Insurance Cost Worksheet

Aon Form-2 Insurance Cost Summary

Aon Form-3 Enrollment Application

Aon Form-5 Notice of Work Completion

Exhibit 1 Sample Certificate of Insurance (Acord 25)

Exhibit 2 Sample Additional Insured Endorsement – General Liability

Exhibit 3 Sample Additional Insured Endorsement – Auto

Treatment Authorization Form

Designated Medical Clinic/Hospital Driving Directions

Form 5020 (CA) – Employer's Report of Occupational Injury or Illness

Form DWC-1 – Workers' Compensation Claim Form

Notice of Occurrence – Liability (Acord 3)

For assistance completing these forms, please contact the UCIP Administrator:

Scott Brama
Aon Risk Solutions
199 Fremont Street, Suite 1500
San Francisco, CA 94105

Phone – (866) 418-8247
Fax – (415) 486-7022
Email – scott.brama@aon.com

Notice of Subcontract Award

Today's Date _____

To:	Scott Brama	**From:**	
Email:	Scott.Brama@aon.com	**Email:**	
Fax #:	415-486-7022	**Fax #:**	
Phone #:	415-486-7566	**Phone #:**	

The subcontractor named below will be issued a contract to perform work on the following:

Project: _____

Contract Number: _____ Contract Value: $ _____

☐ Check here if the subcontractor is to be enrolled in the UCIP
☐ Check here if the subcontractor is to be excluded from the UCIP
☐ Check here if the subcontractor will be an excluded prime tier fabricator with eligible (enrolled) sub-tier erector/installer

1. Name of subcontractor:	
2. Subcontractor address:	
3. Subcontractor FEIN:	
4. Subcontractor contact person:	
5. Subcontractor phone number:	
6. Subcontractor fax number:	
7. Subcontractor email address:	
8. General description of work:	
9. Date of award:	
10 Anticipated on-site start date:	
11. Anticipated completion date:	

Notes –

1. Please attach the subcontractor's *Declaration of Minimum Occupational Safety & Health Qualifications Form* (Exhibit 1b).

2. If available, please attach the subcontractor's certificate of insurance evidencing required coverage.

AON Form-1a

INSURANCE COST WORKSHEET

(Fixed Price Type Contracts)

Numbers reference attached instructions

The University of California
UCIP Project

A. Contractor Information:

Federal ID # or Soc. Sec. #: 1

	▼ Business Information *(headquarters)*	▼ Contact Information *(address questions to..)*
Company Name & dba: Contact Name & Title:	2	3
Address:		
City, State, Zip Code:		
Telephone:		
Fax:		
E.mail Address:		

B. Bid Information:

Bid Package No.: 1

Description of Work: 2

Proposed Contract Price $: 3

Amount of Self Performed Work $: 4

Are you Submitting a bid to The University of California: 5 ❑ Yes ❑ No

If No, identify to whom: 6

C. Workers Compensation Insurance Information for Work Described Above: [a] *(attach a separate sheet if necessary)*

a State	b Class Code	c Description	d Rate *(per $100 payroll)*	e Man-hours	f Payroll	g WC Premium *(Payroll * Rate / 100)*
1						
			Totals	2	3	4

Identify the Amount of Your Claim Retention: 5

Your Company's Workers Compensation Experience Modifier: 6

Modified Premium *(line C4 x C6)*: 7

Employers Liability Rate: 8

Employers Liability Premium: 9

10 Modification & Discount Premium Factors		11 Rate	12 Amount
Mod 1:	+ or -		
Mod 2:	+ or -		
Mod 3:	+ or -		
Mod 4:	+ or -		
Mod 5:	+ or -		

Total Modification Amount *(Total of all amounts entered in column C12)*: 13

Total Workers Compensation Premium *(line C7 + C9 + C13)*: 14

D. General Liability: [a]

Rate: 1

2 Based On: ❑ Total Payroll (C3) ❑ Contract Price (B3) ❑ Other

3 Rate factor: ❑ Per 100 ❑ Per 1,000

4 Identify the Amount of Your Claim Retention:

GL Premium *(D2 x D1 ÷ D3)*: 5

Excess/Umbr Liab: [a]

Rate: 6

7 Based On: ❑ Total Payroll (C3) ❑ Contract Price (B3) ❑ Other

8 Rate factor: ❑ Per 100 ❑ Per 1,000

Excess/Umbr Premium *(D7 x D6 ÷ D8)*: 9

E. Builder's Risk/Installation Floater: [1]

Rate: 1

2 Rate factor ❑ Per 100 ❑ Per 1,000

Builder's Risk/Installation Floater Premium *(B3 x E1 ÷ E2)*: 3

F. Other Insurance Premiums: [1] *(Enter total premium costs identified on page 2)*

1

G. Totals

Total of all Insurance Premiums *(Total of lines C14 +D5 + D9 + E3 + F1)*: 1

Overhead & Profit on Insurance Prem. %: 2 15%

O/H & Profit Amount *(G1 x G2)*: 3

Total Initial Insurance Cost *(Total of lines G1 + G3)*: 4

Contractor's Initial Insurance Cost Rate *(Line G4 divided by total payroll in line C3 x 100)*: 5

H. Signature Block :

I verify the information presented above and attachments are correct:

Name: _____ (please print) Date: _____

Title: _____ Signature: _____

Completion of this form is a required part of your bid and must accompany your bid documents. Complete a separate form for each contractor, known subcontractor(s) and trades not currently awarded to a subcontractor. Duplicate this form as needed.

(a) Please provide copies of the following documents to support your insurance cost calculations:

- ☑ Schedule of Values
- ☑ Workers Compensation declaration and rate pages
- ☑ Experience Modification worksheet
- ☑ General Liability declaration and rate pages
- ☑ Umbrella/Excess Liability declaration and rate pages
- ☑ 5 years actual loss experience for each line of coverage in which Contractor retains more than $5,000.

AON Form-1a

INSURANCE COST WORKSHEET

(Instructions for Fixed Price Type Contracts)

The University of California
UCIP Project

Complete a separate form for each contractor, known subcontractor and trade not currently awarded to a subcontractor. Duplicate this form as needed. Completion of this form is a required part of your bid and must accompany your bid documents.

A. Contractor Information

1 Enter your company's Federal ID number. This number can be found on filings made to the federal government such as your tax return.
2 Enter your company's name, mailing address and phone/fax number for your company's main office location in the space provided below.
3 Enter the name of the person Aon should contact if questions arise. Include the mailing address, phone/fax and e.mail address if different than A-2

B. Bid Information

1 Enter the Bid Package Number, Contract Number or Purchase Order Number that was included in The University of California's originating documentation.
2 Provide a brief description of the work you will be performing at the project site.
3 Identify the total amount of your bid. Include both labor and material.
4 Identify the amount of work that you anticipate will be self-performed. Include both labor and material.
5 Check the appropriate box that identifies if you contract directly with The University of California or are a subcontractor.
6 If you are a Subcontractor, identify the entity with whom you are under contract.

C. Workers Compensation Insurance Information

(Duplicate or attach additional sheets if necessary. You may create an electronic version of this document if all requested information is included):

1 a Enter the two letter abbreviation for the state in which the work will be performed.
b Enter each Workers Compensation class code that applies to your work identified in B2. *(Most states use a 4 digit Number)*
c Enter the Workers Compensation class code description that applies to each class code identified in C1b.
d Enter the Workers Compensation rate that applies to the specified class code.
e Enter the estimated Man-hours required to complete the described work for each Workers Compensation class code.
f Enter the estimated Payroll required to complete your work. Use only unburdened payroll and exclude the premium portion of any overtime pay.
g Calculate the WC Premium by multiplying the Payroll (C1f) by the Rate (C1d) and dividing the result by 100. Repeat this calculation for each WC class code.
2 Total the estimated Man-hours for each class code. Be sure to include information from additional pages if used.
3 Total the estimated Payroll for each class code. Be sure to include information from additional pages if used.
4 Total the Workers Compensation Premium for each class code. Be sure to include information from additional pages if used.
5 Enter the amount of the Claim Retention / Deductible your company has on their existing Workers Compensation.
6 Enter your WC Experience Modifier. This Information can be located on your Workers Compensation policy or on your NCCI Bureau Rating Sheet.
7 Calculate the Modified Premium by multiplying the WC Premium (C4) by the Experience Modifier (C6).
8 Enter your Employer's Liability Insurance Rate. This information can be found in your Workers Compensation policy.
9 Calculate your Employer's Liability Premium by multiplying the Modified Premium (C7) by the Employer's Liab. Rate (C8).
10 Identify the Modifiers that apply to your Workers Compensation Premium. This information can be located on your Workers Compensation Policy.
11 Enter the Rate for each identified Modifier. The information can be located on your Workers Compensation Policy
12 Calculate the Modified Premium Factor Amount by multiplying the Modified Premium (C7) by the Modified Premium Rate (C11) and dividing by 100. Be sure to identify if the Modification factor is an addition or reduction to your premium.
13 Total the Modified Premium Amounts by adding the numbers in column C12.
14 Calculate the Total Workers Compensation Premium by adding the Modified Premium (C7) to the Employer's Liab Premium (C9) and adding the Premium Modifications (C12).

D. General Liability & Umbrella/Excess Liability Insurance

1 Enter the General Liability Rate. This number can be found on your General Liability Policy
2 Identify the base the General Liability Rate applies to. If the base is other than Payroll or Revenue, enter the amount and the description in the space provided.
3 Identify the General Liability Rate factor by marking the box.
4 Identify the amount of your Claim Retention.
5 Calculate the General Liability Premium by multiplying the Bases (D2) by the Rate (D1) and dividing by the factor (D3).
6 Enter the Excess/Umbr Liability Rate. This number can be found on your Excess/Umbr Liability Policy
7 Identify the base the Excess/Umbr Liab. Rate applies to. If the base is other than Payroll or Revenue, enter the amount and description in the space provided.
8 Identify the Excess/Umbr Liability Rate factor by marking the box.
9 Calculate the Excess/Umbr Liability Premium by multiplying the Bases (D7) by the Rate (D6) and dividing by the factor (100 or 1,000).

E. Builder's Risk/Installation Floater

1 Enter the Builder's Risk/Installation Floater Rate. Locate this information on your Property Policy or Builder's Risk Policy.
2 Identify the base factor that it applies to (100 or 1,000).
3 Calculate the Premium by multiplying the Proposed Contract Price (B3) by the Rate (E1) and dividing it by the Factor (E2).

F. Other Insurance Premiums

1 For each of the Insurance Lines of Coverage identified below, Identify the Rate, Base and Factor. Calculate the Premium by multiplying the Base x Rate ÷ Factor. Total the Other Insurance Premiums in the space provided and carry that amount to the front page.

Line of Coverage	Rate	Base	Factor	Premium	Total Premium
Coverage A					

G. Totals

1 Calculate the Total of all Insurance Premium by adding Workers Compensation (C14), General Liability (D5), Excess/Umbr Liability (D9), Builder's Risk/Installation Floater (E3), and Other Insurance Premiums (F1).
2 Identify the Overhead & Profit Percentage that was applied to this project during the tabulation of the Proposed Contract Price.
3 Calculate the Overhead & Profit Amount by Multiplying the Total of all Insurance Costs (G1) by the Overhead & Profit Percentage (G2).
4 Calculate the Total Initial Insurance Cost by adding the Overhead & Profit Amount (G3) with the Total of all Insurance Premium (G1)
5 Calculate your rate by Dividing the Total Initial Insurance Cost (G4) by the Estimated Payroll (C3) and multiplying by 100.

H. Signature Block: This form must be signed by a representative of your company with the authority to Verify the information is correct.

Note: Please provide copies of the following documents as part of your submittal:

- ☑ Schedule of Values
- ☑ Workers Compensation declaration and rate pages
- ☑ Experience Modification worksheet
- ☑ General Liability declaration and rate pages
- ☑ Umbrella/Excess Liability declaration and rate pages
- ☑ 5 years actual loss experience for each line of coverage in which Contractor retains more than $5,000.

AON Form-2	**INSURANCE COST SUMMARY** Numbers reference attached instructions	The University of California UCIP Project

A. Bid Information

Name of Prime Contractor: [1] _____ Bid or Purchase Order No.: [2] _____

Proposed Contract Cost $: [3] _____

B. Aon Form-1a Summary

Contracting Parties & Trades *Aon Form-1a Reference No.*		Proposed Subcontract Amount *B3* *(Form-1a Ref.)*	Estimated Man-hours *C2* *(Form-1a Ref.)*	Estimated Payroll *C3* *(Form-1a Ref.)*	Initial Insurance Cost *G4* *(Form-1a Ref.)*
Prime Contractor : *(Attach the Aon Form-1a)*			1		3
Your Known Subcontractors *(Attach a Separate Aon Form-1a from each)*	4	5	6	7	8
List Additional Trades *NOT* yet assigned to a subcontractor (attach an Aon Form –1a)	9 List by Trade or Function	10	11	12	13
C. Total for Contract: *(Total all Column Entries)*		1	2	3	4
D. Composite Insurance Cost Rate for Contract: *(Line C4 ÷ C3 x100)*					1

E. Signature Block: I verify the information presented above and attachments are correct:

Name: _____ Date: _____
(please print)

Title: _____ Signature: _____

Completion of this form is a required part of your bid and must accompany your bid documents. Duplicate this form as needed. An Aon Form-1a must be attached for each line entry made on this form. In addition, the following documentation must accompany each Aon Form-1a.

- ☑ Schedule of Values
- ☑ Workers Compensation declaration and rate pages
- ☑ Experience Modification worksheet
- ☑ General Liability declaration and rate pages
- ☑ Umbrella/Excess Liability declaration and rate pages
- ☑ 5 years actual loss experience for each line of coverage in which Contractor retains more than $5,000.

AON Form-2	INSURANCE COST SUMMARY INSTRUCTIONS	The University of California UCIP Project

This form is to be used by a Prime Contractor to summarize subcontract activity. This form may also be used by Subcontracts that must summarize sub subcontract activity of any tier. Submit this form with your Bid Documents.

A. Bid Information

1 Enter the Name of the Contractor whose activity is being summarized. For purposes of these instructions they will be called a Prime Contractor regardless of the fact that they may not hold a contract directly with The University of California.

2 Enter the Bid Package Number, Contract Number or Purchase Order Number. This number accompanied The University of California's original documentation.

3 Enter the Amount you have proposed as the Contract Price.

B. Aon Form-1a Summary *(Information will either be found on the Contractor's Aon Form-1a or in situations where the subcontract uses additional tiers of subcontractors, the information will be found on an Aon Form-2 that summarizes their activity with their subcontracted activity.)*

		Aon Form-1a Reference No.	Aon Form-2 Reference No
1	For the Prime Contractor enter the Estimated Man-hours	C2	
2	For the Prime Contractor enter the Estimated Payroll	C3	
3	For the Prime Contractor enter the Total Initial Insurance Cost	G4	
4	For each Subcontractor, enter the firm's Name	A2	A1
5	For each Subcontractor, enter the Proposed Contract Cost	B3	A3
6	For each Subcontractor, enter the Estimated Man-hours	C2	C2
7	For each Subcontractor, enter the Estimated Payroll	C3	C3
8	For each Subcontractor, enter the Total Initial Insurance Cost	G4	C4
9	For the Activity that has *not* been assigned to a Subcontractor, enter the Trade or Functional Description	A2	
10	For the Activity that has *not* been assigned to a Subcontractor, enter the Estimated Contract Amount	B3	
11	For the Activity that has *not* been assigned to a Subcontractor, enter the Estimated Man-hours	C2	
12	For the Activity that has *not* been assigned to a Subcontractor, enter the Estimated Payroll	C3	
13	For the Activity that has *not* been assigned to a Subcontractor, enter the Estimated Initial Insurance Credit	G4	

C. Total Estimates for Contract

1 Total the Proposed Subcontract Amount for the identified activity.

2 Total the Estimated Man-hours for the identified activity.

3 Total the Estimated Payroll for the identified activity.

4 Total the Initial Insurance Cost for the identified activity.

D. Composite Insurance Cost Rate for Contract

1 Calculate the Composite Rate for the Contract by dividing the Total Initial Insurance Cost (C4) by the Total Estimated Payroll (C3) and multiplying by 100.

E. Signature Block: This form must be signed by a representative of your company knowledgeable of its accuracy.

Completion of this form is a required part of your bid and must accompany your bid documents. Duplicate this form as needed. An Aon Form-1a must be attached for each line entry made on this form. In addition, the following documentation must accompany each Aon Form-1a.

- ☑ Schedule of Values
- ☑ Workers Compensation declaration and rate pages
- ☑ Experience Modification worksheet
- ☑ General Liability declaration and rate pages
- ☑ Umbrella/Excess Liability declaration and rate pages
- ☑ 5 years actual loss experience for each line of coverage in which Contractor retains more the $5,000.

AON Form-3

ENROLLMENT APPLICATION

Numbers reference attached instructions

The University of California
UCIP Project

Examine your current Workers Compensation and General Liability Policies or contact your Insurance Agent to assist you with completing this form. *** NOTICE *** Enrollment is not automatic and requires the satisfactory completion of the Aon Form-1a or Form-1b, Form-2 and Form-3. In addition, submit a Certificate of Insurance providing evidence of your *off-site* coverage. Please refer to the Insurance Manual for coverage requirements.

A. Contractor Information:

Federal ID # or Soc. Sec. #: 1

	▼ Business Information *(headquarters)*	▼ Contact Information *(address questions to..)*
Company Name & dba: Contact Name & Title:	2	3
Address:		
City, State Zip Code:		
Telephone:		
Fax:		
Email Address:		

Indicate your Organization's Structure: 4 ❑ Corporation ❑ Partnership ❑ S-Corporation ❑ Joint Venture ❑ Sole Proprietor ❑ Other _____

B. Contract Information:

Contract No.: 1

Date Contract Awarded: 2

Description of Work: 3

Proposed Contract Price $: 4

Amount of Self Performed Work $: 5

Are you Submitting a bid to The University of California: 6 ☐ Yes ☐ No

If No, identify to whom: 7

Start Date: 8 ❑ Actual ❑ Estimated

Completion Date: 9 ❑ Actual ❑ Estimated

C. Contacts: *(Complete if Applicable)*

Position	1 Name & Title	2 Phone	3 Fax	4 Email address
Project Mngr:				
Res. Engineer:				
Insurance:				
Contract Admin:				
Payroll:				
Claims:				
Safety Rep:				

Provide Location of payroll records if different than Corporate address: 5

City, State, Zip Code:

Phone:

Fax:

D. Workers Compensation Insurance Information for Work Described Above: *(attach a separate sheet if necessary)*

a State	b Class Code	c Description	d Man-hours	e Payroll
1				
		Totals	2	3

E. Provide your current *Off-Site* Workers Compensation Information: *(for each state you will perform work in)*

Applicable State	Risk ID Number	Rating Bureau	Anniversary Rating Date
1	2	3	4

Your WC Insurance Carrier: 5

Policy #: 6

Effective Date: 7

Expiration Date: 8

F. Subcontract Information: List all Subcontractors that will be working for you on this project (complete the information in the following table). Use additional paper if necessary:

1 Subcontractor	2 Subcontract $	3 Contact Person	4 Address	5 Phone & Fax No	6 Estimated Start Date

G. Enrollment Questions: *Answer* each question. Use additional paper if necessary.

1 Will you have any off-site location(s) 100% dedicated to this project? ❑ Yes ❑ No If yes, please provide address:

_____

2 Please check if: ❑ Any aircraft used on this project ❑ Any watercraft used on this project

3 Please indicate if labor from the following sources will be used: ❑ Employee Leasing Firm ❑ Temporary Labor Agency

4 _____

5 _____

6 _____

7 _____

H. WARRANTY APPLICABLE TO PROGRAM INSURANCE COVERAGE

1 Premiums for this Program are the responsibility of *The Regents of the University of California* and I agree any and all return of premium, dividends, discounts, or other adjustments to any Program policy(ies) is assigned, transferred and set over absolutely to *The Regents of the University of California*. This assignment applies to the Program policy(ies) as now written or as subsequently modified, rewritten or replaced. Rights of Cancellation for all Program insurance policy(ies) arranged by *The Regents of the University of California* are assigned to *The Regents of the University of California*.

2 I will pay the cost of premium(s) for non-Program insurance coverage, specified in the Contract Documents.

3 I authorized the release of all claim information for all insurance policies under this Program.

4 It is my responsibility to notify my insurance carrier(s) that I am enrolling in this Program.

5 I have omitted from my bid the insurance costs for the coverage provided by *The Regents of the University of California*.

6 The statements in this insurance application are true to the best of my knowledge.

I. Signature Block : I verify the information presented above and attachments are correct:

Name: _____ Date: _____
(please print)

Title: _____ Signature: _____

Fax or Mail to: Scott Brama
Aon Risk Insurance Services West, Inc.
199 Fremont Street, Suite 1500
San Francisco, CA 94105

Phone: (415) 486-7566
Fax: (415) 486-7022

Scott.brama@aon.com

AON Form-3	**ENROLLMENT APPLICATION** **INSTRUCTION**	The University of California **UCIP Project**

This form must be completed and submitted by each successful Contractor and Subcontractor of any tier prior to Site mobilization for each contract awarded. The Contractor and Subcontractor will submit the completed form to Aon Risk Services. Upon receipt of this form, Aon will issue to the Contractor or Subcontractor a Certificate of Insurance evidencing coverage in the Controlled Insurance Program. The completed Certificate of Insurance and Workers Compensation insurance policy will be mailed to the Enrolled party.

A. Contractor Information

1 Enter your company's Federal ID number. This number can be found on filings made to the federal government such as your tax return.
2 Enter your company's name, mailing address and phone/fax number for your company's primary office location.
3 Enter the name of the person Aon should contact if questions arise. Include mailing address, phone/fax and e.mail address, if different than A2.
4 Identify your company's legal structure by checking the box that applies. If the correct legal structure is not specifically listed, please check the "Other" box and specify in the space provided.

B. Contract Information

1 Enter the Contract Number or Purchase Order Number that was included in The University of California's originating documentation.
2 Supply the Date this Contract was awarded to your organization.
3 Provide a brief description of the work you will be performing at the project site.
4 Identify the total amount of your contract. Include both labor and material.
5 Identify the amount of work that you anticipate will be self-performed. Include both labor and material.
6 Check the appropriate box that identifies if you contract directly with The University of California or are a Subcontractor.
7 If you are a Subcontractor, identify the entity with whom you are under contract.
8 Enter the Date you anticipate starting work and then mark whether the date provided is actual or estimated.
9 Enter the Date you anticipate completing the described work and then mark whether the date provided is actual or estimated.

C. Contacts *(Requested Contact information is for specific functions. It is possible to have a single person fulfill multiple responsibilities.)*

1 Identify the name of the person and their title for each function. These individuals should be located, if at all possible, on-site.
2 Provide the phone number for each person identified above.
3 Provide the fax number for each person identified above.
4 Provide the e.mail address for each person identified above, if applicable.
5 Identify the physical location where your payroll records are retained. Provide the Address, City, State, Zip Code, Telephone, Fax Number and E.mail Address of the person responsible for maintaining the payroll information.

D. Workers Compensation Information *(Duplicate or attach additional sheets if necessary. You may create an electronic version of this document if all requested information is included.):*

1 a Enter the two letter abbreviation for the state in which the work will be performed.
b Enter each Workers Compensation class code that applies to the work identified in B2. (Most states use a 4 digit Number)
c Enter the Workers Compensation class code description that applies to the work identified in D1b.
d Enter the estimated Man-hours required to complete the described work by Workers Compensation class code.
e Enter the estimated Payroll required to complete the described work for each Workers Compensation class code. Use only unburdened payroll and exclude the premium portions of any overtime pay.
2 Total all estimated Man-hours for each class code. Be sure to include information from additional pages if used.
3 Total all estimated Payroll for each class code. Be sure to include information from additional pages if used.

E. Current *Off-Site* Workers Compensation Information *(Information relates to your corporation's existing coverage; identify each modification factor that applies.)*

1 Enter the State that the Modification Information applies to.
2 Enter your Bureau File Number also referred to as your Risk Identification Number. This number can also be found on your Modification worksheets.
3 Enter the Bureau Rating Agency. In most states this is NCCI.
4 Provide your Company's Anniversary Rating Date. Information can be located on your bureau's WC Experience Modification worksheets.
5 Identify your insurance carrier for Workers Compensation Coverage.
6 Provide your Workers Compensation Policy Number.
7 Provide the effective date of your Workers Compensation policy.
8 Provide the expiration date of your Workers Compensation policy.

F. Subcontractor Information *(Provide the following information for each Subcontractor that will be performing work at the project site. Use additional sheets, if necessary.)*

1 Identify the name of the Subcontracting firm.
2 Provide the estimated value of the subcontracted activity.
3 Provide a contact name, preferably the project manager, for the Subcontractor.
4 Provide the mailing address for the Subcontractor.
5 Provide the phone number for the Subcontractor.
6 Provide the date the Subcontractor is scheduled to begin work.

G. Enrollment Questions

1 Determine if you will have any locations, off-site, that will be 100% dedicated to this project. Include material/supply storage as a possible location. Mark the appropriate box (yes/no). If you answer yes – provide the address of each location you identified as 100% dedicated.
2 Mark the box or boxes that apply. Contemplate only work performed under this contract.
3 Mark the box or boxes that apply. Employee Leasing Firm are those firms that supply the labor force for your company *(You direct the activities of the Leasing Company's employees*). Temporary Labor Firms supplement your labor force.

H. Warranty Statements:

1-6 Read each Warranty statement thoroughly. If you have questions regarding any of these statements, contact the Aon administrator identified on page 2.

I. Signature Block: This form must be signed by a representative of your company knowledgeable of its accuracy.

Forward the completed Enrollment Application to the Aon administrator identified at the bottom of page 2 of this form. The administrator prior to the start of your work on-site must receive this form.

AON Form-5	NOTICE OF WORK COMPLETION Numbers reference attached instructions	The University of California UCIP Project

A. General Information

Contractor Name: 1

Under contract With: 2

Contract #: 3 UCIP Project

Description of Work: Performed: 4

Date Work Completed: 5

Date this Contract Completed: 6

Final Contract Value: 7

B. Work Completion

The following Subcontractors have completed their Work at the Project Site:

(Add attachment if more space is needed)

a Subcontractor's Name	b Contract Number	c Description of Work	d Date Completed
1			

Location of your payroll records *(Receipt of this form will initiate the payroll audit process)*:

Address: 2

City, State, Zip Code:

Contact/Phone #:

C. Signature Block

The undersigned acknowledges request for termination of Coverage under the OCIP as of the date indicated above for the specified Contract. Should we return to the work Site, we will be working under our own insurance program and must provide *The University of California* with a Certificate of Insurance showing our own Coverage as detailed in our contract.

Signed by: 1

Name & Title Date

Approved by: 2

Construction Manager (Name & Title) Date

Fax or Mail to: Scott Brama
Aon Risk Insurance Services West, Inc.
199 Fremont Street, Suite 1500
San Francisco, CA 94105

Phone: (415) 486-7566
Fax: (415) 486-7022

Scott.brama@aon.com

AON Form-5	NOTICE OF WORK COMPLETION Instructions	The University of California UCIP Project

This form will be completed and returned to the UCIP Administrator by the contractor or Subcontractor whenever work is completed for each Contract or Subcontract. This form will initiate the final payroll audit process for the Contractor/Subcontractor identified in item 1. Final Payments and Release of Retainage will not occur until all payroll work is complete and finalized.

A. General Information

1 Provide the name of the Contractor completing their work.

2 Provide the name of the entity your contract is with (The University of California or Parent Contractor)

3 Enter the contract number for the work being completed.

4 Provide a brief description of the work being completed.

5 Provide the Date the Work was completed.

6 Provide the Date the Contract was completed, if other than work completion date.

7 Document final contract value (original contract amount plus change orders, purchase orders or work orders)

B. Work Completion

1a Enter the name of each Subcontractor that performed work for you that has also completed their work.

b Enter Subcontractors Contract Number.

c Provide a brief description of their work.

d Provide the Date they completed their work.

2 Identify the physical location of where your payroll records are retained. Provide the Address, City, State, Zip Code, Contact Name and Telephone Number of the person responsible for maintaining the payroll information for audit purposes.

C. Signature Block

1 This form must be signed by a representative of your company with the authority to Verify that the information is correct.

2 Have this form approved by the Construction Manager for the Project Site.

Exhibit 1 – Sample Certificate of Insurance

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 01/11/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Insurance Broker/Agent Name & Address	CONTACT NAME: Broker Name PHONE (A/C, No, Ext): Broker Phone — FAX (A/C, No): Broker Fax E-MAIL ADDRESS: Broker Email Address	
	INSURER(S) AFFORDING COVERAGE	**NAIC #**
	INSURER A : Carrier Name	
INSURED Contractor / Subcontractor Name & Address	INSURER B : Carrier Name	
	INSURER C : Carrier Name	
	INSURER D : Carrier Name	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	**GENERAL LIABILITY** [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [x] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC	X	X	Policy Number	Date	Date	Each Occurrence $2,000,000 General Aggregate $2,000,000 Products - Comp Op Agg $2,000,000 Personal & Adv. Injury $1,000,000 Damage to Rented Prem. $50,000 Medical Expense $5,000
B	**AUTOMOBILE LIABILITY** [X] ANY AUTO [X] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS	X	X	Policy Number	Date	Date	Combined Single Limit $1,000,000
C	[X] **UMBRELLA LIAB** [X] OCCUR [ ] **EXCESS LIAB** [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $	X	X	Policy Number	Date	Date	Each Occurrence See Section 4 Aggregate See Section 4
D	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [ ] **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below		X	Policy Number	Date	Date	[X] WC STATU-TORY LIMITS [ ] OTH-ER E.L. Each Accident $1,000,000 E.L. Disease - Each Employee $1,000,000 E.L. Disease - Policy Limit $1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

(The General Contractor and/or Construction Manager should be added if they are not the named insured), The Regents of the University of California, The University of California, University, the UCIP Administrator, and each of their Representatives, consultants, officers, agents, employees, each of their Representative's consultants, and all enrolled parties regardless of whether or not identified in the Contract Documents or to the Contractor in writing, are included as additional insureds on the general liability policy as required by contract and pursuant to additional insured endorsement CG2010 (11/85) or a combination of both CG 2010 (10/01) and CG 2037 (10/01) but only in connection with ___(name of project)___. Coverage is primary and non-contributory as respects off-site coverage. Waiver of Subrogation is included for General Liability and Workers Compensation. **General Liability and Workers' Compensation Coverages apply off-site only.**

CERTIFICATE HOLDER

The Regents of the University of California
c/o Aon Risk Insurance Services West, Inc,
Attn: UCIP Administrator
199 Fremont Street, Suite 1500
San Francisco, CA 94105

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Exhibit 2 – Sample Additional Insured Endorsement – General Liability

POLICY NUMBER: **XXXXXXXXXXXX** COMMERCIAL GENERAL LIABILITY
CONTRACTOR NAME

Sample

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED — OWNERS, LESSEES OR CONTRACTORS (FORM B)

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART.

SCHEDULE

Name of Person or Organization:

TBD (General Contractor), the University of California, the University's consultant and its consultants, the UCIP Administrator, and each of their respective officers, agents, and employees

(If no entry appears above, information required to complete this endorsement will be shown in the declarations as applicable to this endorsement.)

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of “your work” for that insured by or for you.

PRIMARY INSURANCE: This insurance will be primary for the additional insured but only with respect to liability arising out of your work for that additional insured by or for your.

NOTE: This policy to include a WAIVER OF SUBROGATION.

CG 20 10 11 85

Exhibit 3 – Sample Additional Insured Endorsement – Auto

POLICY NUMBER **XXXXXXXX** COMMERCIAL AUTO
CONTRACTOR NAME

Sample

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED

This endorsement modifies insurance provided under the following:

BUSINESS AUTO COVERAGE FORM
GARAGE COVERAGE FORM
TRUCKERS COVERAGE FORM
BUSINESS AUTO PHYSICAL DAMAGE COVERAGE FORM

This endorsement changes the policy effective on the inception date of the policy unless another date is indicated below.

Endorsement effective	
Named Insured	Countersigned by

(Authorized Representative)

SCHEDULE

Who is an insured is changed to include as an "insured" the named insured listed below.

Insurance Company:

Additional Insured: **TBD – (General Contractor), the University of California, the University's consultant and its consultants, the UCIP Administrator, and each of their respective officers, agents, and employees**

Address:

Description of operations/vehicle **As respects to all operations performed for or on behalf of the Additional Insured**

PRIMARY INSURANCE: This insurance will be primary for the additional insured but only with respect to liability arising out of your work for that additional insured by or for your.

NOTE: This policy to include a WAIVER OF SUBROGATION.

UNIVERSITY CONTROLLED INSURANCE PROGRAM (UCIP)

UNIVERSITY OF CALIFORNIA

SAMPLE

TREATMENT AUTHORIZATION FORM

Please present this form to the medical provider's front desk

Address: **TBD**
TBD
TBD

Phone: TBD

Office Hours: TBD – Friday
TBD – Saturday

Contractor OR Subcontractor: _____ **UCIP WC Policy#:** _____

Insurance Company: Zurich Insurance **SITE CODE:** _____

Contact Person: _____ **Contact Phone:** _____

Employee: _____ **Date of Injury:** _____

☐ Authorization for Work Injury Treatment

Drug Screen

☐ **Non-DOT Quick Test**

Reason: ☐ ***Post Accident*** ☐ ***For Cause***

Comments: _____

_____

DIRECTIONS:

- TBD
- TBD
- TBD
- TBD
- TBD

EMERGENCY & AFTER HOURS INJURIES

TBD
TBD
Phone: TBD
Hours: 24 Hours & Emergency Services

ATTENTION

Zurich Billing Information:

Zurich - W.C. Claims
1400 American Lane
Schaumburg, IL 60196

Tel: (877) 928-4531
Fax: (877) 962-2567

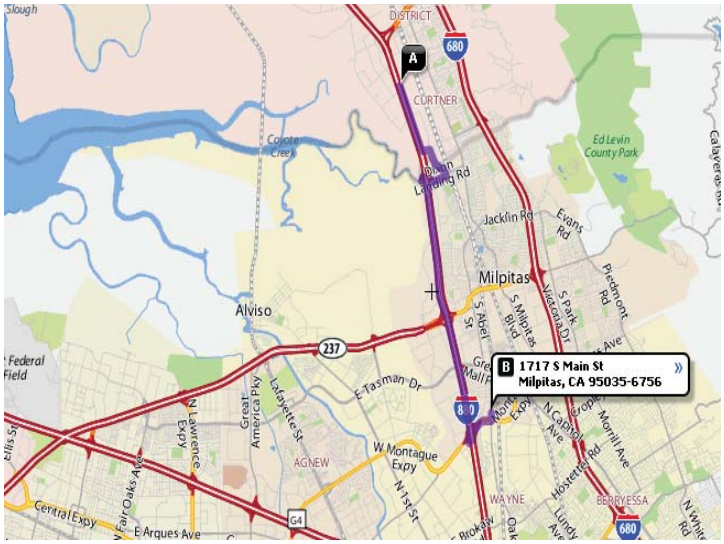
UNIVERSITY CONTROLLED INSURANCE PROGRAM (UCIP)

UNIVERSITY OF CALIFORNIA

SAMPLE

Clinic

US Healthworks Medical Group
1717 S. Main Street, Milipitas, CA 95035
(408) 957-5700
Hours: M-F 7am – 7pm



DIRECTIONS FROM PROJECT SITE
47488 Kato Road, Fremont, CA 94538

- Start out going **SOUTHEAST** on **KATO RD** toward **PAGE AVE**..
- Turn **RIGHT** onto **MILMONT DR**.
- Turn **RIGHT** onto **DIXON LANDING RD**.
- Merge onto **I-880 S** toward **SAN JOSE**.
- Take the **MONTAGUE EXPWY** exit, **EXIT 7**.
- Take the **MONTAGUE EXPWY EAST** ramp.
- Merge onto **MONTAGUE EXPY**.
- Turn **LEFT** onto **S MAIN ST**.
- **1717 S MAIN ST** is on the **LEFT**.

24 Hours - Urgent Care / Hospital

Washington Hospital
2000 Mowry Ave, Fremont, CA 94538
(510) 797-1111

DIRECTIONS FROM PROJECT SITE
47488 Kato Road, Fremont, CA 94538

- Start out going **NORTH** on **KATO RD** toward **AUBURN ST**.
- Turn **RIGHT** onto **W WARREN AVE**.
- Turn **LEFT** onto **WARM SPRINGS BLVD**.
- Turn **LEFT** onto **MISSION BLVD/CA-262 W**.
- Merge onto **I-880 N** toward **OAKLAND**.
- Take the **MOWRY AVENUE** exit, **EXIT 17**, toward **CENTRAL FREMONT**.
- Turn **RIGHT** onto **MOWRY AVE**.
- **2000 MOWRY AVE** is on the **RIGHT**.

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:
INSURER – Zurich North America Insurance
Telephone Reporting- 877-928-4351

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. There is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor or medical group. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Different rules apply if your employer is using a Health Care Organization (HCO) or a Medical Provider Network (MPN). A MPN is a selected network of health care providers to provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to be liable for up to $10,000 in treatment until the claim is accepted or rejected.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, for most injuries you will receive temporary disability payments for a limited period of time. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Se adjunta el formulario para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el administrador de reclamos, quien es responsable por el manejo de su reclamo, le notificará sobre su elegibilidad para beneficios.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos. Los beneficios no pueden comenzar hasta, que el administrador de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Hay un límite para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con la responsabilidad total para tratar su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico o grupo médico previamente designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas differentes que se aplican cuando su empleador usa una Organización de Cuidado Médico (HCO) o una Red de Proveedores Médicos (MPN). Una MPN es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una HCO o una MPN. Hable con su empleador para más información. Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

Dentro de un día después de que Ud. Presente un formulario de reclamo, su empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a la presunta lesión y será responsable por $10,000 en tratamiento hasta que el reclamo sea aceptado o rechazado.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal para la mayoría de las lesions por un period limitado. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos

be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Supplemental Job Displacement Benefit (SJDB): If you were injured after 1/1/04 and you have a permanent disability that prevents you from returning to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation (DWC), or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC website at www.dwc.ca.gov.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el administrador de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado u otro trabajo podría ser temporal o podría extenderse dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. Se lesionó después del 1/1/04 y tiene una incapacidad permanente que le impide regresar al trabajo dentro de 60 días después de que los pagos por incapacidad temporal terminen, y su empleador no ofrece un trabajo modificado o alternativo, es posible que usted reúna los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales basado en su porcentaje de incapacidad permanente.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que viven en el hogar y que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (El Codigo Laboral sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División Estatal de Compensación de Trabajadores *(Division of Workers' Compensation – DWC)* o puede escuchar información grabada, así como una lista de oficinas locales llamando al **(800) 736-7401**. Ud. también puede consultar con la pagína Web de la DWC en www.dwc.ca.gov.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó consulte con la pagína Web en **www.californiaspecialist.org**.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

6/10 Rev.

GENERAL LIABILITY NOTICE OF OCCURRENCE / CLAIM

DATE (MM/DD/YYYY)

AGENCY	INSURED LOCATION CODE	DATE OF LOSS AND TIME ☐ AM ☐ PM
	CARRIER	NAIC CODE
	POLICY NUMBER	
CONTACT NAME:		
PHONE (A/C, No, Ext):		
FAX (A/C, No):		
E-MAIL ADDRESS:		
CODE: SUBCODE:		
AGENCY CUSTOMER ID:		

INSURED

NAME OF INSURED (First, Middle, Last)			INSURED'S MAILING ADDRESS
DATE OF BIRTH	FEIN (if applicable)		
PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL		PRIMARY E-MAIL ADDRESS:
			SECONDARY E-MAIL ADDRESS:

CONTACT ☐ CONTACT INSURED

NAME OF CONTACT (First, Middle, Last)		CONTACT'S MAILING ADDRESS
PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL	
WHEN TO CONTACT		PRIMARY E-MAIL ADDRESS:
		SECONDARY E-MAIL ADDRESS:

OCCURRENCE

LOCATION OF OCCURRENCE STREET:	POLICE OR FIRE DEPARTMENT CONTACTED
CITY, STATE, ZIP:	REPORT NUMBER
COUNTRY:	
DESCRIBE LOCATION OF OCCURRENCE IF NOT AT SPECIFIC STREET ADDRESS:	
DESCRIPTION OF OCCURRENCE (Attach ACORD 101, Additional Remarks Schedule, if more space is required)	

TYPE OF LIABILITY

PREMISES: INSURED IS ☐ OWNER ☐ TENANT ☐	TYPE OF PREMISES	
OWNER'S NAME & ADDRESS (If not insured)	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
	PRIMARY E-MAIL ADDRESS:	
	SECONDARY E-MAIL ADDRESS:	
PRODUCTS: INSURED IS ☐ MANUFACTURER ☐ VENDOR ☐	TYPE OF PRODUCT	
MANUFACTURER'S NAME & ADDRESS (If not insured)	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
	PRIMARY E-MAIL ADDRESS:	
	SECONDARY E-MAIL ADDRESS:	
WHERE CAN PRODUCT BE SEEN?		

AGENCY CUSTOMER ID: _____

INJURED / PROPERTY DAMAGED

NAME & ADDRESS (Injured/Owner)		EMPLOYER'S NAME & ADDRESS	
PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
PRIMARY E-MAIL ADDRESS:		PRIMARY E-MAIL ADDRESS:	
SECONDARY E-MAIL ADDRESS:		SECONDARY E-MAIL ADDRESS:	
AGE / SEX / OCCUPATION		DESCRIBE INJURY	
WHERE TAKEN		WHAT WAS INJURED DOING?	
DESCRIBE PROPERTY (Type, model, etc.)	ESTIMATE AMOUNT	WHERE CAN PROPERTY BE SEEN?	

WITNESSES

NAME AND ADDRESS	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
	PRIMARY E-MAIL ADDRESS:	
	SECONDARY E-MAIL ADDRESS:	
NAME AND ADDRESS	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
	PRIMARY E-MAIL ADDRESS:	
	SECONDARY E-MAIL ADDRESS:	
NAME AND ADDRESS	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
	PRIMARY E-MAIL ADDRESS:	
	SECONDARY E-MAIL ADDRESS:	

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

REPORTED BY	REPORTED TO

– Last Page –