Statewide Educational Wrap Up Program (SEWUP) JPA

Owner Controlled Insurance Program (OCIP)

Project Insurance Manual


www.sewup.org

Program Administrator:

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Preface

About This Manual

- Identifies responsibilities of the various parties involved in the project
- Provides a basic description of the OCIP coverage and program structure
- Describes audit and administrative procedures
- Provides answers to basic questions about the OCIP
- Claim reporting procedures
- Will be updated as necessary

This Manual Does Not

- Provide OCIP coverage interpretations
- Provide complete information about OCIP coverages (Refer to OCIP policies)
- Provide answers to specific claims questions

1.0 Introduction

The Statewide Educational Wrap Up Program JPA (SEWUP), of which this school district is a member, is providing an Owner Controlled Insurance Program for work performed at specific project sites, on behalf of the district, who is the "Owner".

The OCIP provides the following insurance for all eligible and enrolled contractors, providing direct labor, regardless of tier, that are approved for participation in the OCIP.

- **Workers' Compensation & Employers Liability**
- **Commercial General Liability**
- **Builder's Risk**
- **Contractor's Pollution Liability**

Note

The guidelines in this manual are to be used for informational purposes only. This manual does not constitute a contractual agreement. If conflicts exist between this manual and OCIP Insurance Policies, or this manual and the Contract between the District, Construction Manager, and Contractor (Enrolled Parties), OCIP Policies or Owner's Contract will govern.

1.1 Contractor Eligibility

Eligible Contractor includes all Contractors/Subcontractors providing direct labor on the Project. Temporary labor services and leasing companies are to be treated as Eligible Contractors.

Ineligible Contractor includes, but is not limited to, consultants; suppliers who do not perform or do not subcontract installation; demolition that includes abatement and hazardous materials removal; vendors; materials dealers; surveyors; consultants; guard services; non-construction janitorial services; and truckers, including trucking to the Project where delivery is the only scope of work performed. However, if contracted with an on-site installer, suppliers/vendors should be enrolled in the OCIP only for General Liability, as it pertains to the contractual relationship of the installer's on-site work. Ineligible contractors will be required to adhere to insurance certificate requirements as stated in section 4.3, under Contractor-Provided Insurance Coverage. In addition, any party deemed an Ineligible Contractor, but who has direct labor on the Project, will be required to participate in the Project Safety Program (see Section 5).

Any questions regarding a Contractor's status as "Eligible" or "Ineligible" should be referred by written request to Owner.

1.2 Participation

Participation in the OCIP is mandatory but not automatic. Each Eligible Contractor must follow the enrollment requirements, as specified in Section 4.

Enrollment (Definition): An Eligible contractor is not enrolled until the Program Administrator receives and approves a completed Contract Enrollment Form, for each awarded contract, prior to commencement of on-site activities. Evidence of Insurance for work performed off-site is a requirement, as specified in Section 4.3. These documents must be submitted with the completed Contract Enrollment Form.

1.3 Project Site and Offsite Premises

Coverages provided by the OCIP are Project Site specific. The Project-Site must be designated by the Owner. The Project Site consists of any and all projects that are endorsed to this policy, which includes the:

- Ways and means adjoining the endorsed project site.
- Adjacent locations to the endorsed projects sites where incidental operations are being performed, excluding permanent locations.

With the exception of 1 and 2 mentioned above, off-site locations, labor and operations are not covered by the OCIP. It will be the responsibility of each contractor to maintain off-site insurance, as identified in Section 4.3, which specifies coverage types and minimum limits. Contractor will promptly furnish to the Owner, or their designated representative, Certificates of Insurance evidencing that all required insurance is in force.

2.0 Information Directory

2.1 Program Administrator

Keenan & Associates - SEWUP Department
2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501
Phone: 800.654.8102
Fax: 310.787.8838

Questions Regarding OCIP

Refer questions concerning the OCIP, its administration or coverages to the Program Administrator. There are answers to frequently asked questions in Section 8 of this manual.

2.2 Insurance Companies

Workers' Compensation	Zurich American Insurance Company
General Liability	Zurich American Insurance Company
Builder's Risk	Zurich American Insurance Company
Contractor's Pollution Liability	Steadfast Insurance Company

Emergency: 911

All Claims Reporting *

* See Section 6 For Claims Reporting Instructions and Procedures.

3.0 OCIP Coverages

Description of Owner Controlled Insurance Program (OCIP) Coverages

The OCIP is for the benefit of the Owner and all Enrolled Contractor/Subcontractors who have on-site employees. OCIP coverage applies only to Work performed under the contract at the Project Site specified by the Owner. All Contractors must provide their own insurance for Automobile Liability and off-site locations, labor, and operations. The following coverages are provided by the OCIP:

- **Workers' Compensation and Employers Liability**
- **Commercial General Liability**
- **Builder's Risk**
- **Contractor's Pollution Liability**

OCIP Disclaimer

The OCIP is intended to provide broad coverages and high limits, to all Enrolled Contractors/Subcontractors. The Owner does not warrant or represent that the OCIP coverages constitute an insurance program that completely addresses the risks of the Contractors/Subcontractors. Prior to contract award, it is the responsibility of all Contractors/Subcontractors to ensure that the OCIP coverages provided sufficiently address their insurance needs. Upon request, OCIP policies are available for review.

3.1 Workers' Compensation and Employer's Liability Insurance

All Enrolled Contractors/Subcontractors will receive their own Workers' Compensation policy.

Coverage A – Workers Compensation

Liability imposed by the Workers' Compensation and/or Occupational Disease statute of the State of California or governmental authority having jurisdiction related to the work performed on the Project.

Coverage B – Employers Liability

$1,000,000 Bodily Injury each Accident
$1,000,000 Bodily Injury by Disease – Policy Limit
$1,000,000 Bodily Injury by Disease – Each Employee

Contractor Deductible: None

3.2 Commercial General Liability Insurance

All Enrolled Contractors/Subcontractors are considered Named Insured under SEWUP's Master General Liability policy. This Master policy is available for review by Contractors/Subcontractors, upon request to the Owner or the Program Administrator.

Primary Coverage: Limits for Bodily Injury and Property Damage

$10,000,000	General Annual Aggregate – per Project [1]
$5,000,000	Each Occurrence [1]
$5,000,000	Products and Completed Operations Aggregate [1] [2]

Policy Form: "Occurrence" Form

Contractor Deductible: None

Note:

(1) This insurance does not provide coverage for products liability of any enrolled party for any product manufactured, assembled or otherwise worked upon away from the Project Site.

(2) Products and Completed Operations Aggregate is not reinstated annually and is effective for ten (10) years after Notice of Completion is filed by the Owner, or date Occupancy is taken.

Policy Form: "Occurrence" Form

Contractor Deductible: None

3.3 Builder's Risk Insurance

Master policy names the Owner as the "Named Insured" and the Contractors/Subcontractors enrolled in the OCIP will be named "Additional Named Insured". This Master policy is available for review by Contractors/Subcontractors, upon request to the Owner or the Program Administrator.

Primary Coverage

The policy covers materials, supplies, equipment, fixtures, or machinery, which will become a permanent part of the building, or structure at the Project site specified, limited to policy form, policy limit, and exclusions.

Deductible

A deductible, which shall be determined by the type of construction, will apply to each occurrence. The deductible schedule is as follows:

New Construction & Renovation

- $10,000 - $25,000 deductible (depending on type of structure) for Wood Frame, Masonry Non-Combustible or Joisted Masonry, and Fire Resistive / Non-Combustible.
- $50,000 deductible for Water Damage to structural renovations.
- $100,000 deductible for Water damage to Large Span Buildings, (with unsupported roof greater than 200 feet); and Stadiums/Arenas (open air, fixed roof, and/or retractable roof).

The deductible amount will be the responsibility of the contractor suffering the loss or damage and will not be reimbursed by the OCIP Insurance Program.

Note:

All Contractors'/Subcontractors' shall be responsible for any loss or damage to their personal property. This would include, but is not limited to, tools, equipment, mobile construction equipment, or materials NOT intended to be a permanent part of the building, whether owned, borrowed, used, leased, or rented by any Contractor/Subcontractor. Any insurance purchased by the Contractors/Subcontractors, or self-insurance, shall be the Contractors'/Subcontractors' sole source of recovery in the event of a loss.

3.4 Contractor's Pollution Liability Insurance

Master policy names the Owner as the "Named Insured" and the Contractors/Subcontractors enrolled in the OCIP will be named "Additional Named Insured". This Master policy is available for review by Contractors/Subcontractors, upon request to the Owner or the Program Administrator.

Primary Coverage

Bodily Injury or Property Damage from a pollution event as defined within the policy form resulting from covered operations or completed operations.

- $25,000,000 Each Loss / $25,000,000 Program Annual Aggregate
- Claims expense, including defense cost, within limits
- $5,000,000 Fungus/Spore Sub-limit, $5,000,000 Per Claim/Program Aggregate

Deductible:

- $10,000 Per Occurrence

The party legally responsible for any loss or damage shall, to the extent of such responsibility, pay the deductible.

3.5 OCIP Certificates and Policies

All Enrolled Contractors/Subcontractors will receive their own Workers' Compensation policy. Certificates of Insurance will be furnished for the General Liability, Excess Liability (if applicable), Contractor's Pollution Liability, and Builder's Risk coverages. These policies are available for review by the Contractor/Subcontractor, upon request to the Owner or the Program Administrator. Such policies or programs may be amended from time to time and the terms of such policies or programs are incorporated herein by reference. Contractors/Subcontractors hereby agree to be bound by the terms of coverage, as contained in such insurance policies and/or self-insurance programs.

4.0 Contractor Requirements

All Contractors/Subcontractors shall cooperate with, and require their Subcontractors to cooperate with, the Owner and the Program Administrator, in regards to the administration and operation of the OCIP. Each Contractor must include this document with their bid specifications to any and all Subcontractors.

4.1 Enrollment Compliance

Participation in the OCIP is mandatory but not automatic. Each Eligible Contractor/Subcontractor must comply with the following:

An Eligible contractor is not enrolled until the Program Administrator receives and approves the following items:

1) Completed Contract Enrollment Form, for each awarded contract, within ten (10) days of Contract Award and prior to commencement of On-site activities
2) Certificates of Insurance, evidencing Insurance for Workers' Compensation & General Liability coverages for **Off-Site** locations, labor, and operations
3) Certificate of Insurance, including an Additional Insured Endorsement, naming the Owner as an Additional Named Insured, for Automobile Liability for both Project Site and Off-Site operations
4) Policy Declarations pages, including proof of rates from your current policies.

Note:

If there is a discrepancy on the Contract Enrollment Form, evidence of rates (policy rate & declaration sheets), may be requested by the Program Administrator.

OCIP Enrollment Form must be submitted by the following deadlines:

Prime Contractors: Within ten (10) days of Contract Award and prior to commencement of On-site activities

Subcontractors (All Tiers): Within ten (10) days of Contract Award and prior to commencement of On-site activities

All questions regarding enrollment compliance should be directed to the assigned OCIP Administrator.

Any Contractor/Subcontractor who enrolls in the OCIP after their start date will have to provide a No-Known-Loss Letter to the Program Administrator, along with enrollment documentation.

For any work under this contract, and until completion and final acceptance of the work by the Owner, the Contractors/Subcontractors shall, at their own expense, promptly furnish Certificates of Insurance to the Program Administrator before commencing work on the Project Site. Automobile Liability Insurance must be maintained for both Project Site and off-site operations.

4.2 Confirmation of Enrollment Compliance & Evidence of OCIP Coverages

Upon receipt of complete enrollment documents, the OCIP Administrator will acknowledge acceptance of the Eligible Contractor/Subcontractor into the Owner's OCIP, by issuing the following to each Enrolled Party:

1) Confirmation Letter, which will include your assigned Site Location Code required for claims reporting
2) OCIP Certificates of Insurance
3) Claims Kit
4) OCIP Forms
    a. Project Site Monthly Payroll Report
    b. Contractor's Completion Notice

These documents, as issued by the OCIP Administrator, will clearly identify the effective dates of the OCIP coverages for the Contract. A separate Workers' Compensation policy will be issued and sent to each Enrolled Party.

Should an Enrolled Party perform work on several contracts/projects, an Enrollment Form must be completed for each contract. The OCIP Administrator will issue confirmation letters and certificates of insurance to each Enrolled Party for each separate contract. However, only one individual Workers' Compensation policy (that will apply to all contracts/projects) will be issued to each Enrolled Party.

Note:

Verify that the Workers' Compensation effective date, listed on your OCIP Certificate of Insurance, reflect the same date as your start date.

4.3 Contractor-Provided Insurance Coverage

For any work under this contract, and until completion and final acceptance of the work by the Owner, the Contractors/Subcontractors shall, at their own expense, promptly furnish Certificates of Insurance and an Additional Insured Endorsement to the Owner. Copies should be sent to the Program Administrator for both Project Site and Off-Site operations, before commencing work on the Project Site.

All required insurance shall be maintained, without interruption, from the date of commencement of on-site activities, until the date of the final payment or expiration of any extended period. Certificates and additional insured endorsements shall provide not less than thirty (30) days prior written notice to the Program Administrator, of any material change in the insurance, cancellation or non- renewal.

Coverages Requiring an Additional Insured Endorsement

Additional Insured Endorsements, the Owner must be specifically named on the Schedule of an Additional Insured Endorsement, under the section titled, "Name of Person or Organization", as specified below:

1. **All Contractors/Subcontractors** must provide an additional insured endorsement for **automobile liability**.
2. **Ineligible Contractors/Subcontractors** (not enrolled), must provide an additional insured endorsement on both the **Automobile Liability** and **General Liability** policies, and a **waiver of subrogation on workers' compensation.**

   Name of Person or Organization:
   c/o Statewide Educational Wrap Up Program (SEWUP)
   2355 Crenshaw Blvd., Suite 200
   Torrance, CA 90501

Coverages Requiring Certificates of Insurance

Certificates of Insurance will be required, as evidence of the following coverages and limits.

1) **Automobile Liability Insurance.** Must cover all vehicles owned by, hired by, or used on behalf of the Contractors/Subcontractors for both Project Site and off-site operations with the following minimum limits of liability:

Enrolled Contractors/Subcontractors

General/Prime Contractor	Subcontractor	
$2,000,000	$1,000,000	Bodily Injury and Property Damage

Ineligible Contractors/Subcontractors - Not Enrolled

General/Prime Contractor	Subcontractor	
$2,000,000	$1,000,000	Bodily Injury and Property Damage

2) **Workers' Compensation and Employer's Liability Insurance – Statutory Benefits (All States)**
   a. $1,000,000 Bodily Injury each Accident
   b. $1,000,000 Bodily Injury by Disease – Policy Limit
   c. $1,000,000 Bodily Injury by Disease – Each Employee

   Ineligible Contractors/Subcontractors (not enrolled) – must also provide a waiver of subrogation, in favor of the owner.

3) **General Liability Insurance**, to be provided as evidence of coverage for work performed off-site, minimum limits of liability are as follows:

Enrolled Contractors/Subcontractors

General/Prime Contractor	Subcontractor	
$2,000,000	$1,000,000	Bodily Injury and Property Damage
$2,000,000	$1,000,000	Per Occurrence
$2,000,000	$1,000,000	General Aggregate
$2,000,000	$1,000,000	Products/Completed Operations Aggregate
$2,000,000	$1,000,000	Personal/Advertising Injury Aggregate

Ineligible Contractors/Subcontractors - Not Enrolled

General/Prime Contractor	Subcontractor	
$2,000,000	$1,000,000	Bodily Injury and Property Damage
$2,000,000	$1,000,000	Per Occurrence
$2,000,000	$1,000,000	General Aggregate
$2,000,000	$1,000,000	Products/Completed Operations Aggregate
$2,000,000	$1,000,000	Personal/Advertising Injury Aggregate

4) Any other insurance coverage as required by contract

These coverages must be maintained for **Off-Site** labor, locations, and operations. Certificates of Insurance for these coverages must be filed with the Owner and Program Administrator within ten (10) days of Notice of Award, by all Contractors/Subcontractors and prior to commencement of on-site activities. All required insurance shall be maintained, without interruption, from the Notice to Proceed date, until the date of the final payment or expiration of any extended period. The Owner must be named as the Certificate Holder, c/o Statewide Educational Wrap Up Program, as specified below:

Certificate Holder:
(Insert School District Name)
c/o Statewide Educational Wrap Up Program
2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501

Furthermore, the policies shall provide not less than thirty (30) days prior written notice to the Program Administrator, of any material change in the insurance, cancellation, or non-renewal.

4.4 Contractor's Compliance with Other Forms and Procedures

All Eligible Contractors/Subcontractors are required to complete and submit the following forms:

Project Site Monthly Payroll Report

Project Site Monthly Payroll Reports must be submitted to the Program Administrator on a monthly basis, until the completion of the contract. This report must summarize the unburdened payroll by Workers' Compensation Class Code. Certified payroll is not a requirement of the OCIP and cannot be accepted. If

the Project Site Monthly Payroll Report is not submitted to Program Administrator on a monthly basis, the Construction Manager and/or Owner can withhold payment until the report is received. Contractor agrees to keep and maintain accurate and classified records of their payroll for operations at the Project Site. This payroll information is submitted to the OCIP Insurance Carrier. At the end of each contract, a carrier audit may be performed using the reported payroll.

Should no work be performed on the Project Site during a given month, each Enrolled Party is required to submit a form stating that "Non-Performance." For those Enrolled Parties performing Work under multiple contracts, for each contract, a Monthly Payroll Report is required each month until contract is finalized.

1) Workers' Compensation Insurance Rating Bureau Requirements

   Once an Eligible Contractor/Subcontractor is enrolled into the OCIP, the Program Administrator will issue a separate Workers' Compensation Policy. All Enrolled Contractors/Subcontractors will need to comply with the rules and regulations of the California Workers Compensation Insurance Rating Bureau (WCIRB). This requires each Enrolled Party 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 rate will apply to overtime hours worked).

2) Insurance Company Payroll Audit

   Each Enrolled Party must properly classify payrolls, as these are reported to the rating bureau for calculation of future Experience Modifiers for the Enrolled Party's firm. All Enrolled Parties shall make available for inspection and copying their respective company books, vouchers, contracts, documents, and records, of any and all types, for physical inspection by the auditors of the OCIP insurance carrier(s) or Owner'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 OCIP Insurance Policies.

Contractor's Completion Notice

Contractor's Completion Notice must be submitted to the Program Administrator upon completion of work at the Project Site, which includes punch list items, but not warranty or service contract work. This form evidences all enrolled Contractors'/Subcontractors' actual start and completion dates, per each contract. This information is used to confirm that each Workers' Compensation Policy was issued with correct policy term dates, covering the Contractors/Subcontractors for the duration of their Work at the Project Site. This information is subsequently submitted to the WCIRB.

4.5 Additional Requirements of General/Prime Contractor

The General/Prime Contractor and its Subcontractors of all tiers are required to cooperate with Owner and the OCIP Administrator in all aspects of OCIP operation and administration. Specific responsibilities of the General/Prime Contractor include, but are not limited to:

- Include OCIP Contractual Provisions in all subcontracts, as appropriate
- Provide each Subcontractor with a copy of the Project Insurance Manual

  - Notify the OCIP Administrator of all subcontracts awarded
- Require that all eligible Subcontractors performing Work at the Project Site are enrolled in the OCIP prior to working on the Project Site
- Assist in the enforcement of Sub-Contractor compliance with all OCIP requirements
- Cooperate with the OCIP Administrator 's requests for information
- Comply with insurance, claim and safety procedures

5.0 Occupational Safety and Health Compliance

All Contractors/Subcontractors are expected to comply with all applicable local, state, and federal occupational safety and health. If additional safety and health requirements are set forth in the contract specifications, all contractors shall comply with these requirements

It is the responsibility of each Contractor/Subcontractor to maintain an environment free of recognized hazards. All Contractors/Subcontractors shall exercise reasonable care to prevent work-related injuries; property and equipment damage at the Project, as well as minimize risk to the public and third party property.

In the event of an accident, it shall be the responsibility of the employing and/or responsible Contractor/Subcontractor to see that injured workers or members of the public are provided immediate medical treatment. All appropriate medical and claim forms must be filed in accordance with the claim procedures developed for this Project by Keenan & Associates, hereinafter called "Program Administrator." This includes notification to the appropriate state authorities, if necessary.

The Program Administrator shall conduct periodic loss control surveys on behalf of the District. These surveys will focus on evaluating the Contractors'/Subcontractors' efforts to minimize loss, assist in identifying loss exposures, and to recommend appropriate corrective measures. The Program Administrator is a resource to supplement the safety and loss prevention activity of Contractors/Subcontractors. Its loss control survey activities or other activities of the Program Administrator and/or OCIP insurers do not in any way relieve the Contractors/Subcontractors of their responsibilities for Project safety.

In addition local, state, and federal occupational safety and health laws, the following standards apply to all OCIP Enrolled and Non-Enrolled Contractors/Subcontractors.

5.1 Safety Orientation

a. Contractor/Subcontractor employees shall be provided with a project specific safety orientation prior the start of the project. At a minimum, the orientation will address the following items:

   i. The District's site safety requirements.
   ii. Site specific safety hazards and protective measures for these hazards.
   iii. Emergency telephone numbers and procedures.
   iv. Local medical clinic/hospital information within the Medical Provider Network (MPN).

5.2 Program Management

a. Each Contractor/Subcontractors shall have the following safety programs:

   i. Injury and Illness Prevention Plans
   ii. Hazard Communication Programs
   iii. Heat Illness Prevention Plans

b. Each Contractor/Subcontractor shall have an onsite competent person responsible for occupational safety and health.

5.3 Site Safety

According to industry practices, it is the responsibility of contractors of all tiers to exercise reasonable care to prevent work-related injuries; property and equipment damage at the project site, as well as minimize risk to the third-party persons and property. Contractors/Subcontractors of all tiers shall be expected to comply with the following safety and loss control requirements:

a. All Subcontractors shall identify their contact person(s) to the General or Prime Contractor.

b. All Contractors/Subcontractors shall follow District procedures for dealing with the media.

c. All construction employees shall wear clothing suitable for the weather and work conditions. At a minimum, this shall be short sleeved shirts, long pants, and leather or other protective work shoes or boots.

d. Alcohol is prohibited on District property at all times.

e. Contractors/Subcontractors will be required to respond to all District complaints about objectionable levels of dust or noise and will be required to provide prompt and appropriate abatement.

f. Construction personnel cannot enter District grounds other than the construction site unless accompanied by District personnel, and are allowed only "incidental" contact with students. Violations of these requirements by any construction employee will result in a mandatory background check of that employee – including fingerprinting – as required by state law.

g. All prime contractors must attend the site specific pre-construction meeting.

h. No sexual reference or preference shall be permitted on any piece of clothing or the hardhat. Any employee observed disregarding this policy shall be removed from the job site until further notice.

i. All Contractors/Subcontractors shall control the break time activities of the employees to assure the cleanup of all soda cans, food wrappers, plastic bottles, or food containers from the break area. Such areas shall be cleaned immediately after the break and all waste placed in trash receptacles. No glass containers are permitted on the site.

j. Theft or willful damage to any property of the District, student, or other contractors will be prosecuted fully.

k. All Contractors/Subcontractors will advise non-English speaking employees in their native language either in a written format or via an interpreter of these policies.

5.4 Mandatory 6' Fall Protection

a. Contractor/Subcontractor employees shall be protected from fall exposures of **6 feet or greater**. Activities include but are not limited to:

   i. Steel erection
   ii. Decking
   iii. Roofing

iv. Framing
v. Scaffold work

b. A safety monitor as means of fall protection is prohibited.

c. Ladder jacks, lean-to, and prop-scaffolds are prohibited.

d. Contractor/Subcontractors are required to provide training to their employees who might be exposed to a fall hazard prior to the exposure or upon hiring. This training shall be documented and available for review.

e. Methods of fall protection include but are not limited to the following:

i. Railings
ii. Covers for Floor, Roof, and Wall Openings
iii. Personal Fall Arrest Systems, Personal Fall Restraint Systems, and Positioning Devices
iv. Controlled Access Zones

f. The design and construction of railings shall conform to the Cal/OSHA Construction Safety Orders.

g. The minimum parapet height allowed for fall protection is 42 inches or greater.

h. Covers used to cover floor, roof, and wall openings shall be secured in place to prevent accidental removal or displacement and shall be marked in accordance in accordance with Cal/OSHA Construction Safety Orders.

i. Covers used to cover floor and roof openings shall be capable of safely supporting the greater of 400 pounds or twice the weight of the employees, equipment and materials that may be imposed on any one square foot area of the cover at anytime.

j. Controlled access zones shall be defined by a control line or other means that restricts access. Each line shall have a minimum breaking strength of 200 pounds. Signs shall be posted to warn unauthorized employees to stay out of the controlled access zone.

k. Control lines shall consist of ropes, wires, tapes, or equivalent materials. Control lines shall be erected and supported in accordance with Cal/OSHA Construction Safety Orders.

5.5 Crane Safety

a. In accordance with Title 8, California Code of Regulations, section 5006.1, employers shall only permit operators who have a valid certificate (license) of competency to operate cranes. The operator shall have his license on his person, readily available for review.

a. All cranes used in lifting service, exceeding 3 tons rated capacity, and their accessory gear shall not be used until the employer has ascertained that such equipment has been certificated in accordance with Cal/OSHA as evidenced by current and valid documents. Certificates (annual and quadrennial) attesting to current compliance with testing and examination standards shall be maintained, readily available for each crane.

b. The contractor shall provide an erection plan and procedure for erection of trusses and beams over 25 feet long. The erection plan and procedure shall be prepared by a civil engineer

currently registered in California. This plan and procedure shall be followed and kept available on the job site.

5.5 Return To Work:

The District and OCIP Carrier are committed to working with all Enrolled Contractors and Subcontractors to promote the successful & timely return to work of injured employees following a work related injury. The purpose of this policy is to ensure that Enrolled Contractor/Subcontractor employees who temporarily cannot return to their normal duties due to job-related injury or illness, but can safely perform transitional duties while recovering is offered appropriate transitional duties for a limited time only.

a. Each Enrolled Contractor/Subcontractor will cooperate with the OCIP Carrier to facilitate the return to work of any injured employee capable of safely performing transitional duties.

b. When the employee is released to transitional duties, it is the Enrolled Contractor/Subcontractor's responsibility to facilitate the injured employee's return to work.

c. The Enrolled Contractor/Subcontractor is expected to accommodate the injured employee to the fullest extent and facilitate the return to work.

d. It will be the responsibility of the Insurance Carrier's Adjuster to maintain communication with the treating physician and the Enrolled Contractor/Subcontractor to facilitate the prompt return of an employee to full work status.

6.0 Claims Reporting

Accident/Claims Reporting Procedures - Overview

The main responsibility for any Contractor/Subcontractor is to see that any injured worker receives immediate medical care, and to take steps to secure the Project Site against immediate danger. If the injury is serious, call 911 immediately.

6.1 Workers' Compensation Claim Reporting & Procedures

Contractors'/Subcontractors' on-site personnel must follow these procedures if any employee is involved in an accident or occurrence resulting in bodily injury or death:

First Aid Procedures

Should an employee report a work injury or illness that is minor and does not require a doctor visit or time off from work, the supervisor should refer the employee to the nearest first aid treatment available at the site.

If the injury requires a doctor (or medical office) visit or involves lost time, please follow the procedures listed below.

Medical Facilities/Medical Provider Network (MPN)

Zurich North America, the Statewide Educational Wrap Up Program's insurance carrier, has implemented a Medical Provider Network (MPN). This Medical Provider Network (MPN) is to be utilized for all medical treatment of injured employees, unless the employee has pre-designated their medical provider prior to the date of loss.

In emergency situations, it is always recommended that the injured worker be treated at an emergency medical facility first, and then sent to a physician in the Medical Provider Network (MPN). We have provided instructions below on how you can locate a participating medical provider in your area, online or by phone:

- Go to www.zurichna.com
- Click 'Zurich C.A.R.E. Directory Online' in the "My Bookmarks" section
- Type in valid zip code or city + state
- Follow the steps as indicated to locate a medical provider
- You may also contact Zurich at (877) 928-4531 for assistance with finding a medical provider

Information regarding Zurich's Medical Provider Network (MPN) must be communicated to all employees working on a SEWUP project. Once an eligible contractor/subcontractor enrolls into SEWUP, the Program Administrator will provide Zurich's Medical Provider Network (MPN) notification, in both English and Spanish, to be distributed to all employees.

Accident Reporting

Call Zurich at (877) 928-4531 or go to www.zurichna.com to report the injury. Access the Workers' Compensation Claim Kit, sent to you by the Program Administrator, which contains forms to be completed by employee and employer, as well as accident reporting guidelines. Have the following items ready:

- SEWUP Workers' Compensation Policy Number
- SEWUP Site Location Code, which is assigned by the Program Administrator
- Identify your company as being part of the SEWUP

Workers' Compensation Form Requirements

The Labor Code requires that an employee report any injury immediately to the employer. There are essential requirements for both the employer and employee to perform, once the injury has actually been reported.

The Labor Code provides for possible penalties to be assessed if the following time lines are not met:

- Provision of the Employee Claim Form, DWC-1; report within one (1) working day of the employer's knowledge of a disability or injury beyond first aid. Each employer is responsible for providing this form to an injured employee. Should the employee not be available for hand delivery, mail the DWC-1 to the employee at their home address.

- Provision of the Employer's Report of Injury, Form 5020; report, within five (5) days of knowledge, every occupational injury or illness which results in lost time beyond the date of the incident, or requires medical treatment at a medical facility. In addition, every serious illness/injury or death must be reported immediately by telephone or fax to the nearest office of the California Division of Occupational Safety and Health.

6.2 General Liability Claim Reporting

Contractors/Subcontractors must immediately report all third party accidents at the Project Site involving bodily injury, death, or any damage to property to the following:

- Zurich North America – www.zurichna.com or (877) 928-4531

- Program Administrator (SEWUP) – Phone: (800) 654-8102 or Fax: (310) 787-8838

Note:

Always take appropriate emergency measures to prevent additional injury or damage, including contacting police and fire authorities as required by law.

6.3 Builder's Risk Claim Reporting

Contractors/Subcontractors must immediately report all property damage to your work or work of any other Contractor/Subcontractor at the Project Site, to the following:

- Zurich North America – www.zurichna.com or (877) 928-4531
- Program Administrator (SEWUP) – Phone: (800) 654-8102 or Fax: (310) 787-8838

6.4 Contractor's Pollution Liability Claim Reporting

Contractors/Subcontractors must immediately report all third party accidents related to a known or suspected pollution incident at the Project Site involving bodily injury, death, or any damage to property to the following:

- Zurich North America – www.zurichna.com or (877) 928-4531
- Program Administrator (SEWUP) – Phone: (800) 654-8102 or Fax: (310) 787-8838

6.5 Automobile Claim Reporting

NO coverage is provided for automobile accidents under the OCIP. It is the sole responsibility of each Contractor and Subcontractor to report claims involving their automobiles to their own insurance carrier.

6.6 Instructions and Procedures – Litigation Papers, Legal Documents, etc.

If your firm is served with a lawsuit arising out of your involvement with the Owner's Project, or if receipt of litigation papers or legal documents is your first notice of a claim, forward to the following:

- Zurich North America – www.zurichna.com or (877) 928-4531
- Program Administrator (SEWUP) – Phone: (800) 654-8102 or Fax: (310) 787-8838

6.7 Investigation Assistance/Confirmation of Claim Receipt

All Contractors/Subcontractors will assist in the investigation of any accident or occurrence involving injury to persons or property. All Contractors/Subcontractors must 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.

Upon receipt of the claim or incident from the Contractor, the respective OCIP insurance carrier will send a claims acknowledgment letter with the assigned claims file number.

Always cooperate with the Owner or the OCIP insurer representatives in the accident investigation.

7.0 Required Project Forms

7.1 Contract Enrollment Form

7.2 Frequently Asked Questions (FAQ's) for Contractor Enrollment Form

7.3 Project Site Monthly Payroll Report

7.4 Contractor's Completion Notice

7.5 First Report of Injury (5020)

7.6 Workers' Compensation Claim Form (DWC-1)

7.7 ACORD Property Loss Notice

7.1 OCIP Contract Enrollment

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☐ Initial Enrollment ☐ Additional Contract
☐ Change Order ☐ Short term / T & M

OCIP Contract Enrollment Form

Form must be completed by all Contractors/Subcontractors of all tiers for all initial/new contracts and any additional contracts and/or change orders for each project. If using subcontractors, you may use **OCIP Tools Online** to report each subcontractor or complete the "Expected Subcontractors" detail on the next page. **Parent Contractor is responsible for 100% subcontractor compliance with OCIP requirements as set forth in their contract and the SEWUP Project Insurance Manual.**

District: _____ **Project:** _____

CONTRACTOR DETAILS

Contractor Legal Name: _____ ☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ Joint Venture ☐ LLC

DBA or Subsidiary: _____ FEIN#: _____ Contractor License #: _____

Business Address (Address as listed on Insureds Certificate): _____

Office Address (If Different from Business Address): _____

	Contact Name	Phone	Fax	Email
Main Enrollment Contact				
Insurance Contact				
Payroll Contact				
Site Contact/Project Mgr.				

CONTRACT DETAILS

☐ General/Prime Contractor ☐ Subcontractor ☐ Tier Subcontractor ☐ Temp. Labor, Time & Material, or Other: _____ Bid Package #: _____

Awarding Contractor: _____ Prime Contractor: _____

Contract Value: _____ Self Performed Work: _____ % $ _____ Estimated Payroll: _____

Est. # of Subcontractors: _____ Subcontracted Work: _____ % $ _____

If using subcontractors, please be sure to complete subcontractor information on next page

Contract Award Date: _____ Est. Start Date: _____ Est. Completion Date: _____

Description of Work: _____

Off-Site Work Performed? ☐ YES ☐ NO If Yes, Description of Off-site work: _____

CONTRACTORS CURRENT INSURANCE INFORMATION

Insurance Broker or Agency: _____ Agent/Broker Contact: _____

Phone: _____ Fax: _____ Email: _____

WORKERS COMPENSATION INSURANCE

Name of Insurer: _____ WC Policy #: _____ Bureau ID: _____

Effective From: _____ To: _____ Deductible / SIR: _____ Anniversary Rating Date: _____

WORKERS COMPENSATION DETAILS (Estimated Project Site Payroll Only)

WC Class Code	WC Class Code Description	Rate	Est. Man Hours	Est. Payroll	Premium
		$		$	$
		$		$	$
		$		$	$
		$		$	$
				$	$

Was Experience Modifier included in your above WC Class rate(s)? ☐ YES ☐ NO

Subtotals:

Experience Modifier : _____ **Modified Premium:** $

Plus/Minus Rate Deviations or Premium credits: $

Attach Copies of Work Comp rate pages with enrollment form.

(Cost A) **Total Workers' Compensation Cost:** $

Keenan & Associates, 2355 Crenshaw Blvd., Ste. #200, Torrance, CA 90501, Attn: SEWUP Department, Phone (310) 212-0363, Fax (310) 787-8838 License # 0451271

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GENERAL & EXCESS LIABILITY INSURANCE

General Liability Insurer: ______________ General Liability Policy #: ______________

General Liability Effective From: __________ To: __________ General Liability Deductible: __________ or; Retention: __________

Excess Liability Insurer: __________ Excess Liability Policy #: __________ Effective From: __________ To: __________

GENERAL & EXCESS LIABILITY INSURANCE DETAILS (Include Values related to this project contract)

Coverage	Classification Description	Based on Payroll, Receipts or Other	Rate	Per $100 / $1000 or Other	Total Value (Payroll, receipts, or Other)	Liability Premium
General Liability	1.		$	$	$	$
	2.		$	$	$	$
Excess/Umbrella Liability			$	$	$	$
					(Cost B) Total Liability Cost:	$

Attach copies of GL and XL declarations and rate pages with enrollment form.

TOTAL INSURANCE COST

(Cost C) Margin Factor (Apply your Mark-Up Against Current Cost): $

(Cost A +B+C) Total Insurance Cost: $

EXPECTED SUBCONTRACTORS *(If needed, please attach additional sheets including all information requested below.)*

Company Name: __________ Contractor License #: __________ Est. Contract Value: __________

Scope of Work: __________ Est. Start Date: __________ Est. Completion Date: __________

Contact: __________ Phone: __________ Fax: __________ Email: __________

Company Name: __________ Contractor License #: __________ Est. Contract Value: __________

Scope of Work: __________ Est. Start Date: __________ Est. Completion Date: __________

Contact: __________ Phone: __________ Fax: __________ Email: __________

Company Name: __________ Contractor License #: __________ Est. Contract Value: __________

Scope of Work: __________ Est. Start Date: __________ Est. Completion Date: __________

Contact: __________ Phone: __________ Fax: __________ Email: __________

Company Name: __________ Contractor License #: __________ Est. Contract Value: __________

Scope of Work: __________ Est. Start Date: __________ Est. Completion Date: __________

Contact: __________ Phone: __________ Fax: __________ Email: __________

Company Name: __________ Contractor License #: __________ Est. Contract Value: __________

Scope of Work: __________ Est. Start Date: __________ Est. Completion Date: __________

Contact: __________ Phone: __________ Fax: __________ Email: __________

I DECLARE UNDER PENALTY OF PERJURY, UNDER THE LAWS OF THE STATE OF CALIFORNIA, THAT:

1. THE INFORMATION CONTAINED IN THIS DOCUMENT IS TRUE AND CORRECT.
2. I HEREBY UNDERSTAND THAT ENROLLMENT IS CONTINGENT UPON RECEIPT AND ACCEPTANCE OF THIS FORM AND ANY APPLICABLE CERTIFICATES OF INSURANCE. SHOULD I SUBMIT AN INCOMPLETE FORM, KEENAN'S SEWUP DEPARTMENT WILL CONTACT ME AND MY FIRM WILL NOT BE ENROLLED UNTIL I PROVIDE ALL NECESSARY INFORMATION IN ITS ENTIRETY.
3. I HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED IN THE BID SPECIFICATIONS REGARDING THE INSURANCE COVERAGES PROVIDED THROUGH THE OCIP. MY FIRM UNDERSTANDS AND ACCEPTS THE INSURANCE PROVIDED UNDER THIS OCIP.
4. MY FIRM AGREES TO COMPLY WITH THE REQUIREMENTS OF THE OCIP AND FOLLOW THE ADMINISTRATIVE PROCEDURES AS OUTLINED IN THE BID SPECIFICATIONS

Signature: __________ Title: __________ Date: __________

Keenan & Associates, 2355 Crenshaw Blvd., Ste. #200, Torrance, CA 90501, Attn: SEWUP Department, Phone (310) 212-0363, Fax (310) 787-8838 License # 0451271

Frequently Asked Questions (FAQs): Contract Enrollment Form

Contract Enrollment Form

Q: My firm has not been awarded a contract, how can I complete the 'Contract Details' Section on page 1?

A: All information in this section should be completed as an estimate, i.e. who you plan to be have a contract with, estimated start date, estimated contract amount for self-performed work, etc.. You may write 'TBD' for Contract Award Date. Please use estimates for all other categories.

Q: Why do I have to provide my Broker/Agent information?

A: We ask for this information, so that if you request us to do so, we can contact your Broker/Agent for information that you are unsure of, i.e., General Liability rate, etc.

Q: Why do I have to provide my estimated insurance cost for this project if the district is providing insurance coverages?

A: This information is provided to the district so that a comparison can be made between contractor insurance costs and OCIP insurance costs.

Q: How do I complete the 'Workers' Compensation' Section on page 2?

A: Please review the sample on the last page of this document.

Q: Where do I find the Workers' Compensation Class Code(s) and Rate information?

A: You can find this information on your Workers' Compensation Policy Declarations Pages (first few pages of your policy), on the State Fund monthly payroll report form, if applicable, or by contacting your Broker/Agent.

Q: How do I calculate the on-site straight time payroll?

A: The on-site straight time payroll is the base pay for each particular labor classification. In the attached Sample, the company estimates that it will take their apprentice plumbers 150 hours to complete the job. If these apprentice plumbers make $25.00/hr, you would multiply this by 150 hours, which totals $3,750.00 in payroll (150 x $25.00 = $3750).

Q: How do I calculate the WC Premium?

A: You will multiply the on-site straight time payroll by the WC rate and divide by 100. In the example below, (3750 X 15.15)/100 = $568.125 (rounded up = $568.13)

Q: How do I calculate the modified premium?

A: Multiply the Workers' Compensation Experience Modifier by the total WC premium. In the example below, .80 x $1030.13 = $824.10

Q: What do I put in the plus/minus rate deviations or premium credits column?
A: This information can be found on your Workers' Compensation Declarations Pages or by contacting your Broker/Agent. This does not apply to every contractor and can be left blank.

Q: Where do I find the General Liability rate?
A: You will find this on your General Liability Policy Declarations Pages (first few pages of your policy) or by contacting your Broker/Agent. Please note that you may have multiple rates, i.e., a premises-operations rate and a completed-operations rate or you may have GL rates based on your labor classifications, such as one for apprentices and one for journeymen. If you have multiple rates, please add these rates together. Example: premises-ops rate = $6.25 per $100 of payroll and completed-ops rate = $4.50 per $100 of payroll, the total GL rate to be listed on the Contractor Profile is $10.75 per $100 of payroll.

Q: How do I calculate the General Liability premium?
A: Per the example below, if the GL rate is $5.25 per $100 of payroll, the premium would be $472.50. ($9000 (estimated payroll in WC section)/100) x $5.25 = $472.50. An example based on contract value is: contract amount is $25,000: (25,000/100) x 5.25 = $1312.50

Q: I don't have an Excess Liability or Umbrella Policy, how can I complete that section?
A: Please write 'N/A' in this section.

Q: What do I put for Margin Factor?
A: Margin Factor is your profit or mark-up amount. This may not apply to all contractors, please write 'N/A' in this section.

Q: I expect to use multiple subcontractors; can I attach a subcontractor list instead of completing the section on page 3?
A: Yes. You may substitute a typed or handwritten list instead of completing this section.

Q: I just renewed my policies and don't have rate pages and/or certificate of insurance, will this keep me from getting enrolled?
A: No; however, we ask that you contact your Broker/Agent to provide you with proof of coverage and rates on company letterhead. Once your certificate of insurance and policy are received, please forward your rate pages and certificate to the Program Administrator.

Project Name: _____ **Contractor Name:** _____

Each Contractor and Subcontractor of every tier is required to submit a list of job/WC classifications and their respective estimated payrolls and man- hours for all employees that will be working at the project site. This information must be submitted for each

Workers' Compensation Section					
Description of Work	**WC Class Code**	**On-Site Man-hours**	**On-Site Straight**	**WC Rate $100/Payroll**	**WC Premium**
Plumber <$22/hr.	5183	150	3750	15.15	$568.13
Plumber >$22/hr.	5187	150	5250	8.80	$462.00
	Totals	300	$9,000		$1030.13
Modified Premium is: Total Premium X Experience Modifier		Experience Modifier: .80		Modified Premium:	**$**824.10
Plus/Minus Rate Deviations or Premium Credits				Credit/Deduction:	**$**N/A
				Total Workers' Compensation Insurance Cost	**$**824.10
Workers' Compensation Insurance Carrier Name: ABC INSURANCE CO Policy No: ABC-12345 Policy Term: 01-01-07 TO 01-01-08 Workers' Comp Bureau ID No: 123456 Anniversary Rating Date: 01-01-08					
General Liability Section					
General Liability Insurance Carrier Name: DEF INSURANCE CO. Policy No: DEF-5566 Policy Term: 01-01-07 TO 01-01-08 GL Policy Deductible: $100,000 Aggregate Limit: $2,000,000 Per Occurrence Limit: $1,000,000 Products & Comp/Ops Limit: $1,000,000 GL Rate: $5.25 ☐ Per $1000 OR ☒ Per $100 Based On: ☐ Receipts OR ☒ Payroll					
				Total General Liability Insurance Cost	**$**472.50
Umbrella/Excess Liability Section					
Provide your current Umbrella/Excess Liability Carrier Name: N/A Policy No: Policy Term: TO Policy Rate: $ Based On: ☐ Receipts OR ☐ Payroll OR ☐ Other					
				Total Umbrella / Excess Liability Insurance Cost	**$**N/A
				Margin Factor (Apply your Mark-Up Against Current Cost)	**$**N/A
				TOTAL INSURANCE COST	**$**1296.60

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PROJECT SITE MONTHLY PAYROLL REPORT
Due on the 10th of each month (for previous month labor)

District Name: _____ Bid Pkg. #: _____

Project Name: _____ REPORT # _____
(For your Firm's use)

Reporting Month: _____ *Example* ***Feb-2006***

Company Name: _____ Dba Name: _____

Under Contract With: _____ SEWUP Site Code*: _____

*SEWUP Site Code can be found on Accident Claim Reporting Guide or Certificate of Insurance issued for this project, under the Description of Operations section.

Workers' Compensation Class Code	Description	On-site man hours	Payroll*

Is this your final payroll report? ☐ **YES** ☐ **NO**

If Yes, submit final report with Contract Completion Notice. If this is not your final report, payroll must be submitted each month until contract work is complete. If there is no on site labor, 0 hours must be reported and submitted.

I CERTIFY THAT THE INFORMATION REPORTED ABOVE IS TRUE AND ACCURATE. NOT REPORTING ACCURATE PAYROLL INFORMATION COULD AFFECT YOUR EXMOD - EXPERIENCE MODIFICATION RATING WITH THE WORKERS' COMPENSATION INSURANCE RATING BUREAU (WCIRB).

Signature: _____ Title: _____

Print Name: _____ Date: _____

*Only report payroll for work performed on-site. Do not include overtime wage rates, use straight time wage rates only, i.e., employee earns $20/hr. and works 10 hours in one day, you would report $200.00 ($20.00 x 10). Payroll/remuneration that is taxable to employee and paid by your company, is reported to WCIRB.

Keenan & Associates
SEWUP Department
2355 Crenshaw Blvd., Ste. #200,
Torrance, CA 90501
Phone (310) 212-3344, Fax (310) 787-8838

SUBMIT: SEWUP@KEENAN.COM

Keenan Associates

v 090314

Keenan Associates

SEWUP
EDUCATION CONSTRUCTION INSURANCE

Contractor's Completion Notice

District Name _____

Project Name _____

IMPORTANT NOTIFICATION – PLEASE READ

Contractor and Subcontractor agrees to complete this form and return to Keenan & Associates upon completion or termination of work activities under this contract. Please include, with this form, any supporting documents for final contact value (if different from initial contract value).

Contractor/Subcontractor Legal Name: _____

Contractor/Subcontractor dba Name: _____

Address: _____

Site Location Code/
Contract Number: _____

Initial Contract Value: $_____ Final Contract Value: $ _____

Start Date on Site: _____ Last Day on Site*: _____

**This would include work performed on final closeout or punch-list items and should not include warranty work.*

Parent Contractor
(Company Name): _____

Parent Contractor
Contact Name (Print): _____ Title: _____

Signature
(Parent Contractor): _____ Date: _____

Contractor/Subcontractor
Contact Name (Print): _____ Title: _____

Signature
(Contractor/Subcontractor): _____ Date: _____

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Sewup@keenan.com
www.sewup.org

License No. 0451271

Keenan & Associates

Keenan & Associates

District Name: _____

Project Name: _____

State of California **EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS**	PLEASE COMPLETE (TYPE, IF POSSIBLE). MAIL TWO COPIES TO:	**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 of guilty of a felony.

NOTICE: 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 illness/injury 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	DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, City, ZIP)	2A. PHONE NUMBER	Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP)	3A. LOCATION CODE	Ownership
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.	5. STATE UNEMPLOYMENT INSURANCE ACCT NUMBER	Industry
6. TYPE OF EMPLOYER ☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOV. – SPECIFY _____		Occupation

EMPLOYEE

7. EMPLOYEE NAME	8. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH (mm dd yy)	Sex
10 HOME ADDRESS (Number and Street, City, ZIP)		10A PHONE NUMBER	Age
11. SEX ☐ MALE ☐ FEMALE	12. OCCUPATION (Regular job title – NO initials, abbreviations or numbers)	13 DATE OF HIRE (mm dd yy)	Daily Hours
14 EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total wkly. hrs	14A EMPLOYMENT STATUS (check applicable status at time of injury) ___ regular full-time ___ part time temp. ___ seasonal	14B Under what class code of your policy were wages assigned	Days/week
15 GROSS WAGES/SALARY $_____ PER _____	16 OTHER PAYMENTS NOT REPORTED AS WAGES/Salary (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES $_____ PER _____ ☐ NO		Weekly Hours

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm dd yy)	18 TIME INJURY ILLNESS OCCURRED A.M. P.M.	19 TIME EMPLOYEE BEGAN WORK A.M. P.M.	20. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy)	Weekly Wage
21 UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY ☐ YES ☐ NO	22. DATE LAST WORKED (mm dd yy)	23. DATE RETRUNED TO WORK (mm dd yy)	24. IF STILL OFF WORK, CHECK THIS BOX ☐	County
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED ☐ YES ☐ NO	26. SALARY BEING CONT'D? ☐ YES ☐ NO	27. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (mm dd yy)	28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy)	Nature of Injury
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available , e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning				Part of Body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number and Street, City)	30A COUNTY	30B. ON EMPLOYER'S PREMISES ☐ YES ☐ NO		Source
31 DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g. shipping department, machine shop.		32. OTHER WORKERS INJURED/ ILL IN THIS EVENT? ☐ YES ☐ NO		Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold				Sec. Source
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes into truck				Extent of Injury
35 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				
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)			36A. PHONE NUMBER	
37 IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)			37A. PHONE NUMBER	

COMPLETED BY (type or print)	SIGNATURE	TITLE	DATE

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

Formulario de Reclamo de Compensación para 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. For injuries occurring on or after 1/1/04, 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. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. 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 an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same 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, you will receive temporary disability payments. 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.

Si Ud. se lesiona o se enferma, ya sea física 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 para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para 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/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete 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/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta, que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador(a) 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(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con toda la responsabilidad para dar el tratamiento para su lesion 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 pre-designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es possible que Ud. pueda cambiar al médico de su preferencia. Hay reglas especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o depués de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio medico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento applicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares ($10,000).

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación para los trabajadores, sus expedientes médicos no tendrán la misma privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un(a) juez de compensación para trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. Solicita privacidad, es posible que el/la 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. 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 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

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 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.

Vocational Rehabilitation (VR): If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

Supplemental Job Displacement Benefit (SJDB): If you do not return 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. SJDB is a benefit for injuries occurring on or after 1/1/04.

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, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC web site at www.dir.ca.gov. Link to Workers' Compensation.

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**.

días en que Ud. no trabaje, a menos que Ud. sea hospitalizado(a) de 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/la administrador(a) 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 extenderse o no temporalmente, 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.

Rehabilitación Vocacional: Si el doctor dice que su lesión o enfermedad no le permite regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos, hasta un máximo establecido por las leyes estatales. Este es un beneficio para lesiones que ocurrieron antes de 2004.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. No vuelve al trabajo en un plazo de 60 días después que los pagos por incapcidad temporal terminan, y su empleador no ofrece un trabajo modificado o alterno, es posible que usted reúne 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(a) de reclamos pagará los costos hasta un máximo establecido por las leyes estatales basado en su porcentaje del incapicidad permanente. Este es un beneficio para lesiones que ocurren en o después de 1/1/04.

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 vivan en el hogar, que dependían económicamente del/de la trabajador(a) difunto(a).

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Codigo Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por perdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado. Ud. tiene derecho a estar en desacuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador(a) de reclamos, para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios de 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 al Trabajador *(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 ir al sitio electrónico en el Internet de la DWC en **www.dir.ca.gov.** Enlácese a la sección de Compensación para Trabajadores.

Ud. puede consultar con un(a) abogado(a). La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó vaya a su sitio electrónico en el Internet 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

District Name: _____

Project Name: _____

Accord Property Loss Notice Form

ACORD™ PROPERTY LOSS NOTICE — DATE

PRODUCER — PHONE (A/C, No, Ext):	MISCELLANEOUS INFO (Site & location code)	DATE OF LOSS AND TIME	AM / PM	PREVIOUSLY REPORTED	YES / NO
CODE: SUB CODE:	POLICY TYPE	COMPANY AND POLICY NUMBER	NAIC CODE	POLICY DATES	
AGENCY CUSTOMER ID	PROP/HOME	CO:		EFF:	
		POL:		EXP:	
	FLOOD	CO:		EFF:	
		POL:		EXP:	
	WIND	CO:		EFF:	
		POL:		EXP:	

INSURED — **CONTACT** — CONTACT INSURED

NAME AND ADDRESS OF INSURED	DATE OF BIRTH	NAME AND ADDRESS OF INSURED	
	SOC SEC # OR FEIN:		
RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)		
NAME AND ADDRESS OF SPOUSE (IF APPLICABLE)	DATE OF BIRTH	RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)
	SOC SEC # OR FEIN:	WHERE TO CONTACT	WHEN TO CONTACT

LOSS

LOCATION OF LOSS						POLICE OR FIRE DEPT TO WHICH REPORTED	
KIND OF LOSS	FIRE	LIGHTNING	FLOOD	OTHER (explain)		PROBABLE AMOUNT ENTIRE LOSS	
	THEFT	HAIL	WIND				
DESCRIPTION OF LOSS & DAMAGE (Use separate sheet, if necessary)							

POLICY INFORMATION

MORTGAGEE

NO MORTGAGEE

HOMEOWNER POLICIES SECTION 1 ONLY (Complete for coverages A, B, C, D & additional coverages. For Homeowners Section II Liability Losses, use ACORD 3.)

A. DWELLING	B. OTHER STRUCTURES	C. PERSONAL PROPERTY	D. LOSS OF USE	DEDUCTIBLES	DESCRIBE ADDITIONAL COVERAGES PROVIDED
					ON

COVERAGE A. EXCLUDES WIND

SUBJECT TO FORMS (Insert form numbers and edition dates, special deductibles)

FIRE, ALLIED LINES & MULTI-PERIL POLICIES (Complete only those items involved in loss)

ITEM	SUBJECT OF INSURANCE	AMOUNT	% COINS	DEDUCTIBLE	COVERAGE AND/OR DESCRIPTION OF PROPERTY INSURED
	BLDG CNTS				
	BLDG CNTS				
	BLDG CNTS				

SUBJECT TO FORMS (Insert form numbers and edition dates, special deductibles)

FLOOD POLICY	BUILDING:	DEDUCTIBLE:	ZONE	PRE FIRM	DIFF IN ELEV	FORM TYPE	GENERAL	CONDO		
	CONTENTS:	DEDUCTIBLE:		POST FIRM			DWELLING			
WIND POLICY	BUILDING	DEDUCTIBLE	CONTENTS	ZONE	FORM TYPE	GENERAL	CONDO			
						DWELLING				

REMARKS/OTHER INSURANCE (List companies, policy numbers, coverages & policy amounts)/NY ONLY: PREVIOUS ADDRESS OF INSURED & WIFE'S MAIDEN NAME

CAT #	FICO #	ADJUSTER ASSIGNED	ADJUSTER #	DATE ASSIGNED

REPORTED BY	REPORTED TO	SIGNATURE OF INSURED	SIGNATURE OF PRODUCER

ACORD 1 (2000/01) — NOTE: IMPORTANT STATE INFORMATION ON REVERSE SIDE — © ACORD CORPORATION 1988

Applicable in Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Applicable in Arkansas, District of Columbia, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, Pennsylvania and Virginia

Any person who knowingly and with intent to defraud any insurance company or another person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and [NY: substantial] civil penalties. In ME, D.C., LA, and VA, insurance benefits may also be denied.

Applicable in California

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in Florida and Idaho

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony*.
* In Florida – Third Degree Felony

Applicable in Hawaii

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Oklahoma

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

8.0 Frequency Asked Questions (FAQs)

An Owner Controlled Insurance Program (OCIP) Through The Statewide Educational Wrap Up Program (SEWUP)

1. **Who is insured under an Owner Controlled Insurance Program?**
   The Owner and all enrolled Contractors and their enrolled Subcontractors of any tier who perform operations at the Project Site described in the Contract Documents are insured under the OCIP.

2. **Who is managing the Owner Controlled Insurance Program?**
   Keenan & Associates is the Program Administrator for this Owner Controlled Insurance Program, otherwise known as Statewide Educational Wrap Up Program (SEWUP).

3. **Is Project Site Defined?**
   Yes. Project Site is on file with the insurance company, as described in the applicable Contract Documents.

4. **What insurance is provided to Contractors/Subcontractors under the Owner Controlled Insurance Program (OCIP)?**
   The Owner has agreed to procure the following insurance:

   a. Workers' Compensation and Employer's Liability
   b. General Liability Insurance for Personal Injury, Bodily Injury and Property Damage Liability
   c. Builder's Risk
   d. Contractor's Pollution Liability (course of construction only)

5. **Does the OCIP cover any contractor's equipment?**

   No. Contractors and Subcontractors must maintain this coverage.

6. **Are there other types of insurance normally purchased by Contractors, which are not included?**
   Yes. Examples are:

   a. Bonds, if required by contract
   b. Contractor's Automobile Liability and Physical Damage Insurance
   c. Contractor's Equipment Floater

7. **Does the Contractor/Subcontractor insured under the OCIP have to provide evidence of insurance?**
   Yes. The contract requires that, prior to commencement of on-site activities; each Contractor/Subcontractor shall furnish a Certificates of Insurance evidencing coverage for:

   a. Workers' Compensation
   b. General Liability

   Certificates of Insurance and Additional Named Insured Endorsements, specifically naming the Owner, are also required for:

   a. Automobile Liability
   b. Any other required coverages outlined in the Contract and the Project Insurance Manual.

8. **How is the Contractor/Subcontractor's bid to be submitted?**
   The Contractor/Subcontractor needs to submit their bid excluding certain insurance costs, as outlined in the Contract. Change Orders also need to be submitted without insurance costs.

9. **When will the Contractor/Subcontractor receive a Certificate of Insurance insuring them under the OCIP?**
   Eligible Contractors/Subcontractors awarded a contract will be furnished a Certificate of Insurance upon Program Administrator's receipt and acceptance of the Contract Enrollment Form.

10. **Will all Contractors/Subcontractors receive information concerning their loss experience?**
    This information is available, upon request, from the Program Administrator.

11. **How long are the policies kept in-force for the Contractor/Subcontractor?**
    The policy periods commence on the date of "Award" and terminate as defined in the Contract Documents. The only extension is for General Liability "Completed Operations" which is for ten (10) years after Notice of Completion filed by the District.

12. **Does the OCIP provide coverage for truckers, vendors and suppliers?**
    No. Contractors/Subcontractors, whose sole duties are as truckers, vendors, or suppliers are not included in the program. If contracted with an on-site installer, vendors and/or suppliers should be enrolled in the OCIP for General Liability only, as it pertains to the contractual relationship of the installer's on-site work.

13. **Are all Contractors/Subcontractors, of any tier, required to complete and submit their own OCIP forms, before they will be allowed to begin job site activity?**
    All Contractors/Subcontractors, regardless of tier, must complete a Contract Enrollment Form, prior to commencement of on-site activities. Upon acceptance by the Program Administrator, each Contractor/Subcontractor will receive an enrollment confirmation packet, which includes a Certificate of Insurance evidencing the OCIP coverages.

14. **What document do I use to show my Agent/Broker and Insurer that I'm covered under the OCIP?**
    All contractors enrolled under the OCIP program receive individual workers' compensation policies and Certificates of Insurance evidencing coverage under the OCIP program.

Workers' Compensation and Employers' Liability Insurance Questions

1. **What insurance company writes the Workers' Compensation and Employer's Liability coverage?**
   Zurich American Insurance Company.

2. **What is the coverage term?**
   The coverage term for each Contractor/Subcontractor will coincide with the Start Date provided at OCIP enrollment. OCIP Workers' Compensation policies are renewed each year until receipt of OCIP Contractor's Completion Notice.

3. **How will the Contractor/Subcontractor's payroll be classified?**
   Insurance Company will classify payrolls in accordance with California law under the Workers' Compensation Insurance Rating Bureau regulations, classifications, rates and rating plans. The Monthly Project Site Payroll Form will be used for Contractors/Subcontractors' monthly payroll submissions.

4. **Will Program Administrator inspect the job and make recommendations regarding loss control and safety?**
   Yes. The Program Administrator will conduct periodic loss control surveys on behalf of the Owner. These surveys will focus on evaluating the contractors' efforts to control Workers' Compensation, General Liability, and Builders Risk exposures. These surveys are intended to assist contractors in identifying these exposures and take the appropriate actions to minimize the likelihood of loss.

5. **Will there be other people who will make job site inspections?**
   Yes. The insurance company's (Zurich) Risk Engineer may conduct periodic site inspections to verify compliance with State requirements. State, City and Federal inspectors may also make inspections.

General Liability Insurance for Personal Injury, Bodily Injury and Property Damage Liability Questions

1. **What insurance company writes the Personal Injury, Bodily Injury, and Property Damage Liability coverage?**
   Zurich American Insurance Company.

2. **Is Completed Operations coverage provided beyond acceptance of the work performed under the Contract?**
   Yes. The extension for General Liability "completed operations" is for ten (10) years after Notice of Completion is filed by the Owner, or date Occupancy is taken.