The Regents of the University of California
University Controlled Insurance Program
(UCIP)

Bid/Contract Insurance Requirements (Insurance Manual)

for the

University of California, San Francisco Medical Center

Mission Bay Precision Cancer Medicine Building

(Liberty Mutual UCIP III)

this "interim" update: March 25, 2016

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Section 1: About the UCIP

The Regents of the University of California ("University of California", "UC", or the "Sponsor") has elected to implement a University Controlled Insurance Program ("UCIP") that will provide Workers' Compensation, Employer's Liability, General Liability, and Excess Liability coverage for the enrolled Construction Manager/General Contractor, Design-Builder, Prime Contractors (referred to as "Contractor" as appropriate for the type of delivery method), and subcontractors of every tier (collectively referred to as "Subcontractor(s)", unless otherwise specified), for Work on the Project Site. The enrolled Contractor and Subcontractors shall also be referred to as Enrolled Parties.

The UCIP is a single insurance program that also insures UC, the University Campus, and other designated parties. UC will pay premiums associated with the UCIP, subject to verification that the Contract amount is exclusive of all Cost of UCIP Coverage as provided in Section 2 of this manual and unless otherwise stated in the Contract documents.

Note: Participation in the UCIP is mandatory (but not automatic) for all Eligible Parties, unless operations are specifically excluded. Therefore, UC has specified that insurance costs be excluded from all bids and any change orders.

The Enrolled Parties shall have excluded from their bids costs for insurance as set forth in Section 2. Upon award, the selected Contractor and Subcontractors will be required to complete UCIP enrollment information to the UCIP Administrator, who will verify the insurance cost amount identified. The Enrolled Parties will receive approval from the UCIP Broker in the form of a Certificate of Insurance for UCIP coverage, which is issued by the UCIP Administrator.

While the UCIP is intended to provide broad coverage and high limits, the UCIP is not intended to meet all the insurance needs of the Enrolled Parties. **The UCIP does not provide coverage for Professional Liability, Environmental/Pollution Liability, Automobile Liability, Equipment Floaters, or bonds.** It is recommended that the Enrolled Parties discuss the UCIP with their insurance agent or consultant to assure that other proper coverage is maintained.

Note: Insurance coverage 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. It is recommended you have your insurance representative review this information. Any additional coverage you procure will be at your option and expense.

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. Enrolled Parties no longer enrolled in or covered by the UCIP and Excluded Parties shall obtain and maintain, and require each of their Subcontractors of every tier to obtain and maintain, the insurance coverage specified in Section 4.

About this Manual

This Insurance Manual has been prepared by Willis, the UCIP Administrator, the UC, and the University Campus. This manual is designed to provide an overview of the UCIP and identify, define, and assign responsibilities for the administration of the UCIP. This document may be updated from time to time during the course of the Contract and the Enrolled Parties hereby agree that the most current version of this Insurance Manual is binding as part of the Contract. Insurance Manuals will be distributed by the UCIP Administrator to the Contractor and, as requested, to each Subcontractor.

What this Manual Does

This manual:

- Sets forth the responsibilities of the various parties involved at the Project Site, including the insurance-related obligations of the Contractor and Subcontractors of all tiers, whether or not enrolled in the UCIP.
- Describes the general structure of the UCIP.
- Provides a basic description of UCIP coverage.
- 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 coverage.
- Amend, modify, or change the policies.
- Provide coverage interpretations or answer specific claim questions.

Refer questions concerning the UCIP, its administration, insurance coverage, or claims to the appropriate party identified in the UCIP Directory below.

This Manual does not, and is not intended to, provide coverage interpretations, or complete information about coverage. The terms and conditions of the insurance policies will govern how coverage is applied. The information herein is not intended to alter any provisions of the actual contract documents of the Contractor or Subcontractors, and if any such conflict occurs, the contract documents will govern.

UCIP Directory

UCIP Sponsor

The Regents of the University of California, Office of the President, 1111 Franklin Street, Oakland, CA 94607

Title	*Office Number*	*Mobile Number*	*Name*	*E-Mail Address*
Chief Risk Officer	510-987-9289		Cheryl Lloyd	cheryl.lloyd@ucop.edu
Program Manager, Insurance and Construction	510-987-9828		Cindy Low	cynthia.low@ucop.edu

UCIP Broker, Manager, and Administrator

Willis Insurance Services of California, Inc., 525 Market Street, Suite 3400, San Francisco, CA 94105

Title	*Office Number*	*Mobile Number*	*Name*	*E-Mail Address*
Client Manager				
UCIP Safety Manager Northern California				
UCIP Safety Manager Southern California				

Title	Office Number	Mobile Number	Name	E-Mail Address
UCIP Administrator				

UCIP Insurer

Liberty Mutual Insurance, 157 Berkeley Street, Boston, MA 02116

Title	Phone Number	E-Mail Address
Regional Safety Manager		
Claims Reporting		

University Campus

[CAMPUS NAME], [CAMPUS ADDRESS]

Title	Office Number	Mobile Number	Name	E-Mail Address
Program Manager				
Contracts Manager/Administrator				
Campus Director of Risk Management				

Project General Contractor

[PROJECT CONTRACTOR NAME], [CONTRACTOR ADDRESS]

Title	Office Number	Mobile Number	Name	E-Mail Address
Project Manager				
Project Supervisor				
Contractor Safety Manager				

All incidents and accidents are to be reported immediately to the Contractor Safety Manager. For emergencies, also call 911.

UCIP Definitions

The following definitions shall apply throughout this manual:

Additional Insureds	Other parties that UC requires to be added to policies are added as additional insureds. These parties are also referred to as insureds.
Certificate of Insurance	Written evidence of the existence of coverage and terms of an insurance policy.
Contract	A written agreement between the Contractor and the University Campus, a written agreement between the Contractor and prime contractor, or a written agreement between a Subcontractor of any tier and its hiring contractor, as set forth in the Contract documents.
Contractor	The construction management firm, general contracting firm, design-builder firm, or prime contractor firm (referred to as "Contractor" as appropriate for the type of delivery method), under direct Contract with the Sponsor or one of its campuses or medical centers for the overall responsibility of the Project Site during its construction.
Cost of UCIP Coverage	Contractor's or Subcontractor's projected or actual cost to provide the Workers' Compensation and Employer's Liability, Commercial General Liability, and Excess/Umbrella Liability insurance being provided under the UCIP. The Cost of UCIP Coverage 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	Unless Excluded Parties, Contractor and Subcontractors of every tier and such other persons or entities as UC may designate, at its sole discretion, that will perform any labor at the Project Site. Labor may be performed either by the party or by a Subcontractor to a party.
Enrolled Party/Parties	Named insureds on the UCIP policies, which include: 1. A Contractor that is eligible for and enrolls in the UCIP; 2. A Subcontractor that is eligible for and enrolls in the UCIP; 3. Any other Eligible Party that enrolls in the UCIP.

Excluded Parties	Entities that are not enrolled in the UCIP. These include, but may not be limited to: 1. Contractors whose Work includes demolition by means of blasting techniques or wrecking ball; 2. Contractors whose Work includes hazardous materials remediation, removal and/or transportation companies and their consultants; 3. 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); 4. Vendors, suppliers, material dealers, manufacturing representatives, truckers, haulers, drivers, common carriers, equipment rental companies who perform equipment maintenance (does not apply to those who erect or install such rented equipment at the jobsite, or provide operators) 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; 5. Persons or Entities who are not an Eligible Party who are enrolled in the UCIP; and 6. Any other person or entity that the University, acting in its sole discretion, elects to exclude, even if otherwise eligible.
Insured	The Sponsor and the Enrolled Parties that have been named in a policy, Certificate of Insurance, or advice of insurance signed by a duly authorized representative of the Insurers.
Insurer	The companies underwriting insurance coverage provided under the UCIP.
On-Site Activities	Those activities at the Project Site or emanating therefrom. The UCIP does not provide insurance coverage for permanent yards or other locations of the Contractors, except as specifically requested by the Enrolled Contractors and/or University Campus, approved by the Sponsor, and endorsed by the Insurer.
Project Site	[PROJECT NAME] University of California at [CAMPUS LOCATION] [STREET ADDRESS] [CITY, STATE, ZIP] As defined in the Contract documents, the location designated by the Sponsor and on file with Insurer, including approved designated offsite locations.
Sponsor	The Regents of the University of California, also referred to as the University of California or "UC".

Subcontractor	A company providing labor on the Project Site that has entered into a Contract with the University, the Contractor, or a hiring Subcontractor. **All trades are to be enrolled into the UCIP unless the Sponsor specifically approves exclusion or unless an Ineligible Subcontractor.**
UCIP	The University Controlled Insurance Program, which is the program under which Workers' Compensation, Employer's Liability, Commercial General Liability, and Excess Liability are provided to Enrolled Parties while performing operations at the Project Site. The UCIP does not provide coverage for Professional Liability, Pollution Liability, Automobile Liability, Equipment Floaters, or Performance Bonds.
UCIP Administrator	The firm responsible for brokering, managing, and administering the UCIP: • Willis Insurance Services of California, Inc. (identified as "Willis") 525 Market Street, Suite 3400 San Francisco, CA 94105 The firm working for Willis on the Sponsor's behalf, responsible for the day-to-day administration of the UCIP: • MRM Consulting, Inc. 228 Saugatuck Avenue Westport, CT 06880 Refer to the UCIP Directory.
UCIP Broker/Manager	The firm responsible for brokering, managing, and administering the UCIP: • Willis Insurance Services of California, Inc. (identified as "Willis") 525 Market Street, Suite 3400 San Francisco, CA 94105 Refer to the UCIP Directory.
University Campus	The University of California at [CAMPUS OR MEDICAL CENTER NAME]. As defined by the Contract documents, the UC campus or medical center location where the Project Site is located.
Work	All construction, services, and other requirements of the Contract documents as awarded and/or modified by change order, whether completed or partially completed, and includes all labor, materials, equipment, tools, and services provided or to be provided by the Contractor and Subcontractors of all tiers to fulfill the Contractor's obligations. The Work will constitute any part of the Project Site.

Section 2: Applicability of the UCIP

Subcontractors not enrolled in the UCIP shall be required to maintain their own insurance. Coverage types and limits set forth in Section 4 (including, but not limited to, Workers' Compensation, General Liability, Excess Liability, and Automobile Liability) are minimums. Prior to commencing Work at the Project Site, the Enrolled Parties shall promptly furnish the UCIP Administrator with a Certificate of Insurance, giving evidence that all required insurance is in force. Please see the sample certificates of insurance for Contractors' on-site and offsite coverage in Section 7.

Bidding Contractors' Insurance Cost Identification

In all bids, the Eligible Parties to be enrolled in the UCIP shall identify all costs associated with insurance for all of their project Work, including, but not limited to, insurance premiums, expected losses within any retention, or deductible program, using *UCIP Form 1: Enrollment Information*, a copy of which is incorporated in Section 7 of this manual.

By completing and submitting *UCIP Form 1: Enrollment Information*, including supporting documents (copies of policy declaration pages and premium rate pages, as well as a Certificate of Insurance) to the UCIP Administrator, the Eligible Parties warrant that all costs for insurance as described in this section have been correctly identified for the contracted Work on-site.

When completing information on the Excess premium charges on *UCIP Form 1: Enrollment Information*, the Eligible Parties will utilize their particular insurance rate. If an Excess rate is not available and the Eligible Parties' policies are written on a flat premium basis, the Eligible Parties will develop a rate based upon their overall annual payroll or receipts. The payroll (or receipts) will be divided into the Excess premium charge to determine a fair rate to apply to insurance for the Contract.

Coverage and limit requirements for purposes of calculation of the insurance cost on *UCIP Form 1: Enrollment Information*, which are to be excluded from the bid, are described below.

Workers' Compensation and Employer's Liability

Workers' Compensation insurance statutory benefits as provided by state statute and Employer's Liability annual limits:

- $1,000,000 Bodily Injury by Accident, each accident
- $1,000,000 Bodily Injury by Disease, policy limit
- $1,000,000 Bodily Injury by Disease, each employee

Commercial General Liability

- $2,000,000 General Aggregate
- $2,000,000 Products/Completed Operations Aggregate
- $1,000,000 Personal/Advertising Injury Aggregate
- $2,000,000 Each Occurrence Limit

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, and products and completed operations.

Excess Liability/Umbrella

- $2,000,000 Each Occurrence
- $2,000,000 Aggregate

Change Order Pricing

Change Orders submitted by the Enrolled Parties must **exclude** the cost of insurance as specified in this section.

Section 3: UCIP-Provided Coverage

UC, at its sole expense, has implemented the UCIP to furnish certain insurance coverage with respect to On-Site Activities. The UCIP will be for the benefit of UC, the University Campus, and its Enrolled Parties, which have on-site employees. Such coverage applies only to Work performed under Contract at the Project Site. Enrolled Parties must provide their own insurance for offsite activities and coverage not provided by the UCIP (see Sections 3 and 4). Excluded Parties must provide their own insurance for all offsite and on-site activities.

The UCIP Administrator will provide upon enrollment a Certificate of Insurance evidencing Workers' Compensation, General Liability, and Excess Liability coverage to the Enrolled Parties, each of whom will then be a named insured on the UCIP policies. Other documentation, including claim reporting forms, posting notices, etc., will be furnished to the Enrolled Parties. Each Enrolled Party will receive a separate UCIP Workers' Compensation policy issued by the UCIP Insurer and distributed by the UCIP Broker.

Insurance policies are available to Enrolled Parties at www.Willis.com. Please contact the UCIP Administrator for login information.

The terms of such policies or programs may be, from time to time, amended. The Enrolled Parties hereby agree to be bound by the terms of coverage as contained in such insurance policies. If any conflict exists between this Insurance Manual and the UCIP policies, the insurance policies will govern.

Note: The UCIP provides no coverage for Phase 1 Design Development services in CM-at-risk Contracts, or for Phase 1 Design Development and Phase 2 Construction Documents services in design/build Contracts.

The Contractor will be required to provide enrolled insurance limits during the Phase 1 Design Development Work for CM-at-risk Contracts and Phase 1 Design Development and Phase 2 Construction Documents for design/build Contracts.

Through a combination of insured and self-insured programs, UC will provide and maintain in force the types of insurance listed below as a part of the UCIP for all Enrolled Parties. The Enrolled Parties agree that the insurance company policy limits of liability, coverage terms, and conditions shall determine the scope of coverage provided by the UCIP.

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 the UCIP. Your insurance representative should review this information. Any additional coverage you may wish to purchase will be at your option and expense.

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 coverage provided under the UCIP.

Workers' Compensation and Employer's Liability Insurance

Workers' Compensation/Employer's Liability will be provided in accordance with applicable California laws. Limits of liability and coverage will be as follows:

- Workers' Compensation.....California Statutory Benefits

- Employer's Liability:
  - $2,000,000 ..... Bodily Injury by Accident, each accident
  - $2,000,000 ..... Bodily Injury by Disease, policy limit
  - $2,000,000 ..... Bodily Injury by Disease, each employee

Note: All Contractor and Subcontractor premium and loss experience will be reported to the rating authorities for use in calculating their own experience modification. Losses on any UCIP Project Site will directly impact the Contractor's and Subcontractors' future insurance costs; therefore, it is critical, as well as beneficial, for all safety procedures to be followed on the Project Site.

Commercial General Liability Insurance

General Liability will be provided on an "occurrence" form under a master liability policy, reflecting the following limits of liability, coverage, and terms:

- Limits of Liability:
  - $ 4,000,000 ..... General Aggregate (Reinstated Annually)
  - $ 4,000,000 ..... Completed Operations Aggregate
  - $ 2,000,000 ..... Bodily Injury & Property Damage, each occurrence
  - $ 2,000,000 ..... Personal/Advertising injury, each occurrence
  - $ 1,000,000 ..... Fire Damage Legal Liability
  - $ 10,000 ..... Medical Expense
- Coverage and Terms shall include, but not be limited to, the following:
  - Aggregate limits specified are shared by all Enrolled Parties for all projects insured for the University Campus and any associated medical center.
  - Products and Completed Operations Extension is 10 years.
  - This insurance will not provide coverage for products liability to any Insured party, vendor, supplier, offsite fabricator, material dealer, or other party for any product manufactured, assembled, or otherwise worked upon away from the Project Site.
  - This policy contains exclusions. Some of these exclusions are:
    - Real and personal Property in the care, custody, or control of the Insured;
    - Asbestos;
    - Lead;
    - EIFS;
    - Fungi and Bacteria;
    - Discrimination and Wrongful Termination;
    - ERISA;
    - Architects and Engineers Errors & Omissions;
    - Owned & Non-Owned Aircraft, Watercraft, Pollution, and Automobile Liability;
    - Nuclear Broad Form Liability

Note: A single General Liability policy will be issued covering all Insureds.

Excess Liability Insurance

Excess Liability will be provided under a master liability policy for all Insureds reflecting the following Limits of Liability, Coverage, and Terms as follows:

- Limits of Liability:

- — $100,000,000.....Each occurrence Limit
- — $100,000,000.....General Aggregate Limit

- Coverage and Terms include:
  - — Aggregate limits specified are shared by all Enrolled Parties for all projects insured for the University Campus and any associated medical center.
  - — 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 UCIP Commercial General Liability loss, General Contractor shall pay to the University an amount as set forth below. Payment of the General Contractor Obligation shall not in any way limit the liability of General 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 loss, is as follows:

Contract Sum at the Time of Loss	Amount to be Paid (Per Occurrence)
$2,500,000 or Less	$ 10,000
$2,500,001 to $10,000,000	$ 15,000
$10,000,001 to $25,000,000	$ 25,000
$25,000,001 to $50,000,000	$ 50,000
$50,000,001 to $75,000,000	$ 75,000
$75,000,001 or more	$ 100,000

Note: General Contractor and Subcontractors are advised to procure insurance for owned or leased equipment and materials not intended for inclusion in the construction at the Project Site. The UCIP will not cover General Contractor or Subcontractor property.

Coverage of Offsite Locations

Subject to Article 11.1.1 and 11.1.2 of the General Conditions, for purposes of the UCIP, Work that is performed at an offsite location will be treated as on-site Work only if such offsite coverage is offered by the Supplementary Conditions, and provided that:

- The off-site location meets the requirements of the *UCIP Form 4 Coverage Questionnaire for Fabrication at a Dedicated Off-Site Location*.
- The Contractor specifically requests from the University coverage for the offsite location.
- The UCIP Insurer approves enrollment of the location.

The Contractor must complete and submit the *UCIP Form 4: UCIP Coverage Questionnaire for Fabrication at a Dedicated Offsite Location* to the UCIP Administrator with its completed *UCIP Form 1: Enrollment Information*. Persons and entities eligible for such coverage (see Article 11.1.2 of the General Conditions), unless excluded under Article 11.1.5 of the General Conditions, will be required to enroll in the UCIP.

UCIP Termination or Modification

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

Section 4: Contractor and Subcontractor-Provided Coverage

The Contractor and all Subcontractors are required to maintain insurance coverage that protects the University of California from liability from claims or 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.

Note: The UCIP provides no coverage for Phase 1 Design Development services in CM-at-risk Contracts or for Phase 1 Design Development and Phase 2 Construction Documents services in design/build Contracts.

The Contractor will be required to provide enrolled insurance limits during the Phase 1 Design Development Work for CM-at-risk Contracts and Phase 1 Design Development and Phase 2 Construction Documents for design/build Contracts.

There are two types of Contractors and Subcontractors: Enrolled Parties and Excluded Parties.

- Enrolled Parties are to provide evidence of Workers' Compensation and General Liability Insurance for **offsite activities** and Automobile Liability insurance for **both on-site and offsite activities** via Certificate(s) of Insurance with additional insured endorsements as per the insurance specifications in the Contract.
- Excluded Parties (not enrolled) must provide evidence of Workers' Compensation, General Liability, Auto Liability, and other insurance as required by the scope of Work (i.e. Hazardous Remediation Pollution Liability), if any, for all activities, both on-site and offsite, via Certificate(s) of Insurance with additional insured endorsements as per the insurance specifications in the Contract.

Contractor and Subcontractors must submit verification of insurance in the form of a Certificate of Insurance on a standard ACORD 25 form 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 of this Insurance Manual.

Certificates of Insurance must provide 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 noncontributing with respect to any other insurance available to the Additional Insureds.

Pursuant to the instructions to bidders, the Contractor shall provide its Certificates of Insurance to the University Campus, with a copy to the UCIP Administrator, within 10 days after receipt of notice of selection as the apparent lowest responsive and responsible bidder. All Subcontractors of every tier shall provide, prior to mobilization, their Certificates of Insurance directly to the UCIP Administrator.

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

Automobile Liability Insurance

(All Contractors enrolled in and excluded from (not enrolled in) the UCIP)

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 offsite.

Workers' Compensation and Employer's Liability Insurance

(All Contractors enrolled in the UCIP must provide for offsite activities only)
(All Contractors excluded from (not enrolled in) in the UCIP must provide for on-site and offsite activities)

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

Commercial General Liability / Umbrella Liability

(All Contractors enrolled in the UCIP must provide for offsite activities only)
(All Contractors excluded from (not enrolled in) the UCIP must provide for on-site and offsite activities)

	Limits of Liability	
	Enrolled	**Excluded**
• General Aggregate	$ 2,000,000	$4,000,000
• Products/Completed Operations Aggregate	$ 2,000,000	$4,000,000
• 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, and products/completed operations.

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 construction project), whether such equipment is located at the Project Site or "in transit". Contractor and Subcontractors are solely responsible for any loss or damage to their personal property, including Contractor and Subcontractors tools and equipment, temporary structures (including construction trailers) whether owned, used, leased, or rented by the Contractor or 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 of Workers' Compensation and Employer's Liability insurance, the following shall be included as Additional Insureds as required by Contract: The Regents of the University of California, The University of California, the University Campus (by name), 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.

The General Liability insurance policy must name the University Campus as an additional insured pursuant to additional insured endorsement CG2010 (11/85) or a combination of both CG 2010 (10/01 or 07/04) and CG 2037 (10/01 or 07/04). Refer to the sample Certificate of Insurance provided in Section 7 of 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: Contractor and Subcontractor Responsibilities

Throughout the course of the Work at the Project Site, the 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 shall cooperate with the University of California and the UCIP Administrator in the administration and operation of the UCIP. The Contractor's responsibilities shall include, but not be limited to, the following:

- No Eligible Party shall commence Work at the Project Site until it has received a Certificate of Insurance evidencing enrollment in the UCIP or, if determined to be an Ineligible Party, has provided a satisfactory Certificate of Insurance to the UCIP Administrator. Subcontractors eligible for the UCIP, which are on-site but not enrolled, will be removed from the Project Site until enrollment is completed.
- Providing each Subcontractor with a copy of this Insurance Manual. The 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. Said revisions shall replace all previous versions. Copies of any revised Insurance Manual shall be distributed by the Contractor and/or UCIP Administrator.
- Timely notification to the UCIP Administrator of all subcontracts and lower-tier subcontracts.
- Inclusion of the UCIP provisions in all subcontracts. The prime contractor has the responsibility to ensure that all its eligible subcontractors, of all tiers, are enrolled prior to each Subcontractor's commencement of Work.
- Compliance with the applicable construction safety program, administrative procedures, and claim procedures.
- Providing necessary Contract, operations, safety, and insurance information.
- Timely reporting of monthly payrolls to the UCIP Administrator.
- Cooperating with any broker, insurance company, or insurance administrator with respect to requests for claims, payroll, or other information required under the program.
- Attending periodic meetings regarding administration, claims review, or safety, as requested.
- Timely reporting to the Contractor and the UCIP Safety Manager any and all claims or accidents, as well as providing Work status reports to the Contractor following an injury sustained at the Project Site. Additionally, each employer will provide its employees with a Medical Provider Network ("MPN") Packet, available from the Contractor.
- Completing all administrative forms within the time frames required by the UCIP Administrator.

UCIP forms and their descriptions, copies of which are included in Section 7 of this manual, are as follows:

- ***UCIP Form 1: Enrollment Information***
  Prior to starting Work on a Project Site, the Contractor, and all Subcontractors must provide the required documentation for verification of their insurance programs, along with Certificates of Insurance for non-UCIP coverage and Automobile Liability.
- ***UCIP Form 1-A: Notice of Subcontract Award***
  The Contractor and all Subcontractors awarding subcontracts are to provide this completed form to the UCIP Administrator prior to the awarded Subcontractor's mobilization at the Project Site.
- ***UCIP Form 1-B: Declaration of Minimum OSHA and EMR (TO BE SUBMITTED WITH YOUR BID)***

At time of bid: Submit with your bid completed and signed Form 1-B for each identified contractor or sub-contractor.

Upon contract award and prior to commencement of work: Forward a copy of the completed Form 1-B (submitted above) to UCIP Administrator (or complete and sign a new form). For any Subcontractors not identified at time of bid, they must complete and sign Form 1-B and submit to the UCIP Administrator.

By signing Form 1-B, the Subcontractor acknowledges that it meets the following minimum occupational safety and health (OSHA) qualifications:

— The Subcontractor must have had no Final Order (declared by OSHA) willful violations in California of Part 1 (Section 6300) of Division 5 of the Labor Code during the five-year period prior to bid opening.

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

— 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 on the Project Site until it submits this form to the UCIP Administrator.

- ***UCIP Form 2: Payroll Reporting***
  This completed form is to be sent to the UCIP Administrator each month by the 10th of the following month. Payroll breakdowns are required for each Contractor or Subcontractor on the Project Site. Payroll is **unburdened** and by class code. **The UCIP Administrator may request certified payroll records and/or Contractor or Subcontractor agreements to verify Form 2 payroll submissions.**
- ***UCIP Form 3: Notice of Work Completion***
  Upon completion of the Contractor's and/or Subcontractor's Work on the Project Site, this form is completed, signed by the hiring party, and submitted to the UCIP Administrator.
- ***UCIP Form 4: UCIP Coverage Questionnaire for Fabrication at a Dedicated Offsite Location***
  This form and required attachments are required if an offsite location is to be considered for coverage under the UCIP.
- ***Claim Form A: Treatment Authorization***
  This form is to be completed and presented to the authorized treatment facility. Please see Section 6 of this manual for claim reporting procedures.
- ***Claim Form B: California Employer's Report of Occupational Injury or Illness***
  This form is to be completed by the employer of the injured worker and filed with the UCIP Insurer. Please see Section 6 of this manual for claim reporting procedures.
- ***Claim Form C: General Liability Notice of Occurrence or Claim***
  This form is to be completed by responsible Enrolled Party and provided to the Contractor Safety Manager and the UCIP Safety Manager. Please see Section 6 of this manual for claim reporting procedures.

Note: Failure to follow the administrative or claim procedures outlined may result in the withholding of progress payments until compliance.

Responsibilities for Subcontractors

Each hiring party shall require that all its Subcontractors of every tier complete and submit *UCIP Form 1: Enrollment Information* and shall also provide an acceptable Certificate of Insurance, a copy of the declaration page(s), and

premium rate page(s) for each policy to the UCIP Administrator. All Enrolled Parties must receive a Certificate of Insurance from the UCIP Administrator prior to beginning Work on the Project Site. The Contractor and each Subcontractor shall include all of the provisions in this Insurance Manual in every subcontract so that such provisions will be binding upon each Subcontractor of any tier. The Contractor and all Subcontractors should ensure that their subcontract awards are net of the Subcontractor's Cost of UCIP Coverage. Each prime contractor is responsible for the enrollment and deducts for all its tiers of Subcontractors.

Contractor and Subcontractor Bids

The University of California shall pay all premiums for the UCIP. Each bidder is required to submit its bid for the project Work that is net of Contractor's Cost of UCIP Coverage. The section below, titled "Adjustments for UCIP Coverage Costs" describes the procedure for identifying the Cost of UCIP Coverage when bidding so these costs can be removed from the bid price. *UCIP Form 1: Enrollment Information* in Section 7 of this manual contains a worksheet that can be used to estimate your insurance costs for the coverage provided under the UCIP.

Adjustments for UCIP Coverage Costs

Each Eligible Party is required to **exclude** from its bid the cost of the insurance that is provided under the UCIP. A separate *UCIP Form 1: Enrollment Information* is required from the Contractor and all Subcontractors for each Contract on the Project Site.

Each Enrolled Party 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 EMR (Workers' Compensation only).
- Five (5) 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 Party to **exclude** the cost of insurance provided under the UCIP. The Contractor and Subcontractors are responsible for ensuring that their Subcontractors of all tiers also remove the Cost of UCIP Coverage from their bids and Change Orders. The UCIP Administrator will assist in the verification of insurance cost identification calculations.

Enrollment

The Contractor and Subcontractor shall provide details about their Subcontractors to the UCIP Administrator on *Form 1-A: Notice of Subcontractor Award* in order to begin their enrollment process. All Contractors and Subcontractors must complete and submit *UCIP Form 1: Enrollment Information* for **each Contract** on the Project Site. *UCIP Form 1: Enrollment Information* must be completed and submitted to the UCIP Administrator and accepted prior to commencing Work on the Project Site.

Enrolled Parties will receive a Confirmation Letter and UCIP Certificate of Insurance from the UCIP Administrator to confirm acceptance of the applicant into the UCIP for each of its Contracts on the Project Site. These documents will clearly identify the effective dates of the UCIP coverage for the Contract. A separate Workers' Compensation policy

will be issued and sent to each Enrolled Party. Additionally, a Claims Kit will be provided by the Contractor to the Subcontractor upon enrollment into the UCIP.

Note: Enrollment into the UCIP is required, but not automatic. All eligible Contractors and Subcontractors must complete the UCIP enrollment forms and participate in the enrollment process in order to obtain UCIP coverage. Access to the Project Site will not be permitted until enrollment into the UCIP is complete.

Coverage of Offsite Locations

Subject to Article 11.1.1 and 11.1.2 of the General Conditions, for purposes of the UCIP, Work (as defined in Article 1.1.40 of the General Conditions) that is performed at an offsite location will be treated as on-site Work only if such offsite coverage is offered by the Supplementary Conditions and provided that:

- The offsite location meets the requirements specified in *UCIP Form 4: Coverage Questionnaire for Fabrication at a Dedicated Offsite Location*.
- The Contractor specifically requests from the University coverage for the offsite location.
- The UCIP Insurer approves enrollment of the location.

The Enrolled Party must complete and submit *UCIP Form 4: Coverage Questionnaire for Fabrication at a Dedicated Offsite Location* to the UCIP Administrator with its *UCIP Form 1: Enrollment Information*. Persons and entities eligible for such coverage (see Article 11.1.2), including the Contractor and all Subcontractors, unless excluded under Article 11.1.5, will be required to enroll in the UCIP.

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 its facility. Please see the clinic address in Section 6: Claims Reporting Procedures.

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

For insurance purposes, the Enrolled Parties agree, and shall require all tiers of Subcontractors to agree, to keep and maintain accurate and classified records of their payroll for operations under each Contract at the Project Site. The Enrolled Parties further agree, and will require all tiers of Subcontractors to agree, to furnish full and accurate monthly payroll data and information in accordance with the requirements of the UCIP Insurer as provided in *UCIP Form 2: Payroll Reporting*. Such records will limit the payroll for Executive Officers and Partners/Sole Proprietors to the limitations as stated in the state manual rules.

For auditing purposes, each Enrolled Party should provide its own insurance carrier(s) with a copy of its *UCIP Form 3: Notice of Work Completion* upon completion of its Work on the UC Project Site. This will serve as evidence that

the Contract value and payrolls associated with the UCIP Work should not be applied against the Enrolled Party's own policies, since coverage was provided under the UCIP.

Enrolled Parties must submit monthly payroll reports by the 10th of the following month to the UCIP Administrator identifying Work hours and payroll for all Work performed at the Project Site by Contract and by Workers' Compensation classification codes.

While all hours (regular hours and overtime hours) should be included for UCIP payroll reporting, only regular time rates apply to all hours worked. Do not include overtime rates or any benefits.

Payroll Audits

Each Enrolled Party shall permit UC and its representatives to examine and/or audit their books and records and agree to submit backup information in the form of certified payrolls, if requested. The Enrolled Party shall also provide any additional information to UC or its appointed representatives as may be required.

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 UC'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.

Closeout Procedures

Enrolled Parties must submit *UCIP Form 3: Notice of Work Completion* when all Work for each Contract at the Project Site is complete, or when the Enrolled Party no longer has workers on-site. The completed *UCIP Form 3: Notice of Work Completion* will signal the final payroll report for the completed Contract Work and initiate the audit of payroll by the UCIP Insurer. A copy of *UCIP Form 3: Notice of Work Completion* is found in Section 7 of this manual.

Failure to fill out *UCIP Form 3: Notice of Work Completion* and report all payrolls in a timely manner may result in UC withholding issuance of final payment and release of retention pursuant to Article 9 of the General Conditions.

Section 6: Claim Reporting Procedures

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

Please refer to the UCIP Directory in Section 1 of this manual.

Media Inquiries

Make no statements to the media. Refer all questions from the media to the Communications Office at the University location where the Project Site 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

The main responsibility of all parties is to first see that the injured worker receives immediate medical care. For emergency treatment, the paramedics will determine the best emergency facility available for treatment.

For emergencies, dial 911.

Treatment Facilities and Maps/Directions

The designated medical facilities for Enrolled Parties' employees injured on this Project Site are listed below.

For non-emergency injuries:

[OCCUPATIONAL HEALTH CLINIC NAME] [STREET ADDRESS] [CITY, CA ZIP] Phone: [PHONE NUMBER] Hours: [HOURS OF OPERATION] Closed Weekends and Holidays	[INSERT MAP HERE]

- Driving Directions from the Project Site:
  - [DRIVING DIRECTIONS]

For after-hours injuries:

[HOSPITAL NAME] [STREET ADDRESS]	[INSERT MAP HERE]

[CITY, CA ZIP] Phone: [PHONE NUMBER] Hours: 24-Hour Emergency Services	

- Driving directions from the Project Site:
  - [DRIVING DIRECTIONS]

WC Claim Reporting Procedures

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

1. Injured workers should report to the Contractor's Project 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 *Claim Form 1: Treatment Authorization* from the Contractor if they do not already have this form. Please see Section 7 of this manual for a copy of this form.
2. Contact the designated medical facility to advise them that an injured worker will be arriving.
   - Present *Claim Form A: Treatment Authorization* to the clinic or hospital upon registration to identify the injured worker as a UCIP participant working at a UCIP Project Site.
   - The Contractor and injured worker's employer must designate a representative at the Project Site to escort the injured worker to the medical facility.
   - This individual is to remain with the injured worker 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 worker 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 injured worker, his/her employer, and the Contractor Safety Manager.
   - If the work status form is not provided to the Contractor, the Contractor will request a copy from the injured worker's employer.
3. As soon as possible, but always within 24 hours of notice of injury sustained at the Project Site, the employer of an injured worker shall:
   - Fill out Employee and Employer sections of the *Claim Form B: California Employer's Report of Occupational Injury or Illness* and send it in to the insurance company when filing the claim.
   - Provide the injured worker with a copy of the completed *Claim Form B: California Employer's Report of Occupational Injury or Illness*.
   - Conduct a Supervisor's Accident Investigation.

- Report the Claim. **Please see *UCIP Project Claims Kit* for instructions**.

  When an employer reports the claim through one of the above methods, Liberty Mutual, 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. Liberty Mutual will also send a claims acknowledgement to the reporting employer with the assigned claim number and the Liberty Mutual 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 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) assignment for injured workers. Each employer shall have a written early return to work program that shall be implemented on this Project Site 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 California 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 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 its employees. When additional information is requested by the insurance carrier, the employer is required to cooperate with the assigned claims adjuster.

Medical Provider Network

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.
2. The injured worker has not pre-designated his/her own personal physician.

MPN packets will be distributed to all Enrolled Parties by the UCIP Broker 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 its safety orientation to all employees attending the orientation.

Liability Claims

Incidents or accidents at or around the Project Site, including those at a designated offsite location that has been added to the UCIP, resulting in damage to property of others (other than the Enrolled Parties' own Work product), or personal injury or death to a member of the public, must be reported immediately to the designated Contractor and UCIP Safety Managers. The following procedures must be followed in the event of such an 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.

2. Complete *Claim Form C: General Liability Notice of Occurrence or Claim* and report the incident and all subsequent inquiries or correspondence about an insured loss or claim, including a summons or other legal documents, to the Contractor and UCIP Safety Managers.

3. The General Contractor Safety Manager will report the claim. **Please see *UCIP Project Claims Kit* for instructions.**

Automobile Claims

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

However, all accidents occurring in or around the Project Site must be reported to the designated Contractor and UCIP Safety Managers. The accident will be investigated to determine any liability arising out of the project's 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: Forms

The following pages contain the UCIP forms, Certificate of Insurance samples, and Claim forms necessary for the University of California's UCIP.

The forms included in this Section are:

- UCIP Form 1: Enrollment Information
- UCIP Form 1-A: Notice of Subcontract Award
- UCIP Form 1-B: Declaration of Minimum OSHA and EMR (TO BE SUBMITTED WITH YOUR BID)
- UCIP Form 2: Payroll Reporting
- UCIP Form 3: Notice of Work Completion
- UCIP Form 4: UCIP Coverage Questionnaire for Fabrication at a Dedicated Offsite Location
- Claim Form A: Treatment Authorization
- Claim Form B: California Employer's Report of Occupational Injury or Illness
- Claim Form C: General Liability Notice of Occurrence or Claim
- Sample Certificate of Insurance for Non-UCIP Coverage

1. UCIP Form 1: Enrollment Information

Sample (project-specific)

UNIVERSITY OF CALIFORNIA

UCIP Form 1:
Enrollment Information

UC Santa Barbara
Project: San Joaquin Apartments

Contractor/Subcontractor and Contract Information

Company Name:		Hiring Company:	
Street Address (no P.O. Box):		City, State, Zip:	
Contact Name:		Contact Phone:	
Contact E-Mail:		Federal ID #:	
Work Description:		Award Amount:	$
Start Date:		Est. End Date:	
Est. Man-Hours		Est. # Subs:	

Business Type: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ S Corp ☐ Limited Partnership

Insurance Costs Excluded from this Contract (attach a separate sheet as necessary)

WC Class Code	*Workers' Compensation Classification*	*WC Rate*	*Man-Hours*	*Unburdened Payroll (1)*	*WC Premium* (Payroll x Rate / 100)
				$	$
				$	$
				$	$
		WC Subtotals:		$	(A) $

It is extremely important to accurately estimate Project Site payrolls anticipated for this contract.

(1) Unburdened Payroll is all hours but only at regular-time rates (any overtime hours will be included at the regular-time rates).

Experience Modifier		(B)	$
Total Modified WC Premium (A x B)		(C)	$
Apply Modifier 1:	@	(rate)	$
Apply Modifier 2:	@	(rate)	$
Apply Modifier 3:	@	(rate)	$
Apply Modifier 4:	@	(rate)	$
Apply Modifier 5:	@	(rate)	$
Total WC Premium (D)			$

General Liability Code / Rate (Indicate per $100 or $1,000): Indicate Payroll or Receipts with Amount Below:

/	$	$
/	$	$
/	$	$
	Total GL Premium (E)	$

Excess Liability Rate (Indicate per $100 or $1,000): Indicate Payroll or Receipts with Amount Below:

	$ **Total XS Premium (F)**	$

Note: If Excess premium is flat, develop a rate using your GL policy's exposure (payroll or receipts/contract value).

Total of All Insurance Premiums (D + E + F):	(G)	$
Apply % Overhead & Profit on Total of All Insurance Premiums (G):	(H)	$
Total Insurance Cost (G + H) (excluded from this contract):	(I)	$

Agreement:

Premiums for the University Controlled Insurance Program (UCIP) are the responsibility of The Regents of the University of California (Sponsor) and the undersigned agrees that any and all return of premium, dividends, discounts, or other adjustments to any UCIP policy is assigned, transferred, and set over absolutely to the Sponsor. This agreement applies to the UCIP policies as now written or as subsequently modified, rewritten, or replaced. Rights of cancellation for all UCIP insurance policies arranged by the Sponsor are assigned to the Sponsor.

The undersigned will pay the cost of premiums for non-UCIP insurance coverage specified in the Contract Documents and authorizes the release of all claim information for all insurance policies under the UCIP. It is the below Company's responsibility to notify its own insurance carrier(s) that it is enrolled in the UCIP and that the undersigned has omitted from its bid the insurance costs for the coverage provided by the Sponsor. The statements in this insurance application are true to the best of the undersigned's knowledge.

I/We verify the information presented above and attachments are correct.

Signature: _____ Date: _____
Print Name: _____ Title: _____

Complete a separate worksheet for each contract and for each contractor and all subcontractors. Duplicate this form if necessary.
Policy declaration and rating pages and certificate of insurance must be attached with initial enrollment/submission.

Submit Completed Form 1, Policy Pages, and Certificate of Insurance to the UCIP Administrator.

Willis

UCIP Administrator—1720 Post Road East, Suite 221—Westport, CT 06880
Toll-Free Phone: 877-277-1882—E-Mail: UC@mrmriskmanagement.com

2. UCIP Form 1-A: Notice of Subcontract Award

Sample (project-specific)

UNIVERSITY OF CALIFORNIA

UCIP Form 1-A:
Notice of Subcontract Award

University of California
University Controlled Insurance Program

The Subcontractor Named Below Will Be Issued a Contract to Perform Work on the Following:

Campus / Medical Center:	UC Santa Barbara	Contract Number:	
Project:	San Joaquin Apartments	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.

Subcontractor Information:

Company Name:	
Company Address (no P.O. Box):	
Company FEIN:	
Contact Name:	
Contact Phone Number:	
Contact E-Mail Address:	
General Description of Work:	
Date of Award:	
Anticipated On-Site Start Date:	
Anticipated Completion Date:	

Notes/Special Instructions (if any):

Submit to UCIP Administrator;
attach the subcontractor's Certificate of Insurance,
evidencing required coverage, if available.

Willis

UCIP Administrator—1720 Post Road East, Suite 221—Westport, CT 06880
Toll-Free Phone: 877-277-1882—E-Mail: UC@mrmriskmanagement.com

3. UCIP Form 1-B: Declaration of Minimum OSHA and EMR

UNIVERSITY OF CALIFORNIA

UCIP Form 1-B:
Declaration of Minimum OSHA and EMR

University of California
University Controlled Insurance Program

At time of bid: Submit this completed and signed form with your bid for each identified Contractor or Subcontractor.

Upon contract award and prior to commencement of work: Forward a copy of this completed form (submitted above) to UCIP Administrator (or complete and sign a new form). For any Subcontractors not identified at time of bid, they must complete and sign this form and submit to the UCIP Administrator.

Project Name: _____ Project Number: _____

DECLARATION OF CONTRACTOR / SUBCONTRACTOR
MINIMUM OCCUPATIONAL SAFETY AND HEALTH QUALIFICATIONS

Certification Pursuant to Government Code Section 4420

The minimum occupational safety and health qualifications for each Contractor and Subcontractor are as follows:

1) Contractor/Subcontractor has no Final Order (declared by OSHA) Willful violations in California of Part 1 Section 6300 of Division 5 of the Labor Code during the five (5)-year period prior to execution of this certification.

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

3) Contractor/Subcontractor has instituted an injury prevention program pursuant to Section 3201.5 or 6401.7 of the Labor Code and will provide University with a complete copy upon request.

The undersigned certifies that (1) it meets the minimum occupational safety and health qualifications set forth above and, (2) declares, under penalty of perjury, that the foregoing is true and correct.

Company Name: _____

List California License Classifications: _____

Company Address: _____

Signature: _____ Date: _____

Print Signature Name: _____ Title: _____

This declaration was duly executed on the above listed date at:

Name of City (if within a city)	County	State
_____	_____	_____

Willis

UCIP Administrator—525 Market Street, Suite 3400, San Francisco, CA 94105
Toll-Free Phone: 877-277-1882—Toll-Free Fax: 877-277-1886—E-Mail: UC@mrmriskmanagement.com

4. UCIP Form 2: Payroll Reporting

Sample (project-specific)

UNIVERSITY OF CALIFORNIA *UCIP Form 2: Payroll Reporting*

University of California
University Controlled Insurance Program

Campus or Medical Center Name: _____

Project Name: _____

Month / Year: _____ / _____ Prepared By: _____

Company Name: _____ Submitting First Report: ☐

Date Prepared: _____ Submitting Final Report: ☐

On-Site Payroll (All Contracts)

Contract / Job Number	*Contracting For*	*WC Class Code*	*Man-Hours*	*Unburdened Payroll*
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
			Totals:	*$*

Notes/Special Instructions (if any)

1. Include each contract on the project site; attach additional sheets if necessary.
2. All payroll figures should reflect wages only for work performed on the project site.
3. Unburdened Payroll means overtime hours should be calculated at regular-time rates and employee benefits should be removed.
4. If there is no payroll for a calendar month, while still enrolled in the UCIP, an entry for that contract noting ZERO payrolls must be entered and submitted.
5. Payments may be withheld if this form is not submitted as required.
6. Retain this form to present proof to your insurance carrier in the event of an audit.

I/We certify the above is an accurate statement of payroll and/or receipts expended on the above project during the period stated.

Contractor Signature: _____ Date: _____

Print Name: _____ Title: _____

Submit to UCIP Administrator by the 10th of each month for the previous month's contract work on-site.

Willis

UCIP Administrator—525 Market Street, Suite 3400, San Francisco, CA 94105
Toll-Free Phone: 877-277-1882—Toll-Free Fax: 877-277-1886—E-Mail: UC@mrmriskmanagement.com

5. UCIP Form 3: Notice of Work Completion

Sample (project-specific)

UNIVERSITY OF CALIFORNIA *UCIP Form 3: Notice of Work Completion*

UC Santa Barbara
Project: San Joaquin Apartments

Section I:

Company Name:	Contact Name:
Subcontracting for:	Phone:
FEIN:	E-Mail:
Start Date:	Completion Date:

Section II:

Original Contract Value:	$	Total Submitted Payrolls:	$
Change Order Amounts:	$	Total Submitted Man-Hours:	
Final Contract Amount (including any sub-tier contracts):	$		
Final Self-Performed Contract Amount (less sub-tier contract amounts):	$		

Above Company's Sign-Off:

We hereby verify that all contract work (including the work of subcontractors) has been completed and all payrolls have been submitted.

Company's Signature: _____ Date: _____

Print Name: _____

Hiring Contractor's Sign-Off:

We hereby verify that the above contractor's work (including the work of subcontractors) has been completed and all payrolls have been submitted.

Hiring Contractor Signature: _____ Date: _____

Print Name: _____ Hiring Contractor Company Name: _____

Submit to UCIP Administrator.

Willis

UCIP Administrator—1720 Post Road East, Suite 221—Westport, CT 06880
Toll-Free Phone: 877-277-1882—E-Mail: UC@mrmriskmanagement.com

6. UCIP Form 4: UCIP Coverage Questionnaire for Fabrication at a Dedicated Offsite Location (page 1 of 2)

University of California
University Controlled Insurance Program

UNIVERSITY OF CALIFORNIA

Form 4: UCIP Coverage Questionnaire for Fabrication at a Dedicated Offsite Location

(page 1 of 2)

1. Name and address of the UC project site at which your company will perform work.

2. Your company's name and address.

3. Will your company be performing work at the above project site location?
   (If No, the dedicated off-site location cannot be covered.)

   Note: (Transport, pick up, delivering or carrying materials, personnel, parts or equipment, or any other items or persons to or from the project site do not qualify as performing work.)

4. Do the operations to be performed at the dedicated offsite location fall into the categories listed as Excluded Parties in Section 1 "UCIP Definitions" of the Insurance Manual?
   (If Yes, the dedicated off-site location cannot be covered.)

   Note: Excluded Parties include, but are not limited to, the following:
   - Heavy and/or structural demolition, hazardous materials remediation, removal and/or transport companies and their consultants;
   - Architects, surveyors, engineers, soil testing engineers, and their consultants (except for architects, surveyors, engineers, and soil testing engineers that are employees of a Contractor);
   - Vendors, suppliers, fabricators, material dealers, truckers, haulers, drivers, common carriers, and other that 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 person to or from the Project Site;
   - Temporary labor services;
   - Any other person or entity that the University, acting in its sole discretion, elects to exclude, even if otherwise eligible.

5. Will the dedicated offsite location be 100% dedicated to the UC project site identified in Item 1 above?

   a. If No, will the work to be performed at the off-site location be segregated by a specific, clearly identifiable time period wherein only UC project work will be performed?

   Note: If work cannot be clearly segregated by a specific, clearly identifiable time period wherein only UC project work is to be performed with work logs evidencing the work run date, work run time, workers who performed the work, and provide a UC dedicated storage area for the specified time, the location cannot be covered.

6. If the location meets the 100% dedicated requirements, please provide:

   a. Dedicated off-site location address ***(must be within California, or it cannot be covered).***

Willis

UCIP Administrator—525 Market Street, Suite 3400, San Francisco, CA 94105
Toll-Free Phone: 877-277-1882—Toll-Free Fax: 877-277-1886—E-Mail: UC@mrmriskmanagement.com

UCIP Form 4: UCIP Coverage Questionnaire for Fabrication at a Dedicated Offsite Location (page 2 of 2)

University of California
University Controlled Insurance Program

UNIVERSITY OF CALIFORNIA

Form 4: UCIP Coverage Questionnaire for Fabrication at a Dedicated Offsite Location

(page 2 of 2)

b. Describe scope of the work to be performed at the dedicated off-site location for the UC project identified in Item 1 above.

c. Describe the work process to be performed

d. What are the dates and times in which only UC work for the UC project identified in Item 1 above will be performed and unfinished and finished materials stored at this off-site location?

Note: If approved by the insurance carrier, coverage will only be in effect during the time period during which the work is being performed. The date of coverage cannot be earlier than enrollment into UCIP nor can it be in the past.

7. Attach a Certificate of Insurance with the address of the dedicated offsite location to evidence coverage for non-UC work being performed.

8. Attach a copy of your site safety plan.
   a. Site plan must also include the name and qualifications of a designated and secondary (backup) credentialed CSP that will be on site at all hours of operations.
   b. This information will be provided to and must be approved by the insurance carrier prior to the dedicated offsite location being scheduled.
   c. If the location is scheduled onto the UCIP, by signing below, you agree to allow insurance carriers and any other safety professionals to perform periodic safety reviews at your offsite location during the time the UC work is being performed, and you will comply with all loss control recommendations as outlined in a safety report.

I/We verify the information presented above and attachments are correct.

Signature: _____ Date: _____
Print Name: _____ Title: _____

Submit to UCIP Administrator

Willis
UCIP Administrator—525 Market Street, Suite 3400, San Francisco, CA 94105
Toll-Free Phone: 877-277-1882—Toll-Free Fax: 877-277-1886—E-Mail: UC@mrmriskmanagement.com

7. Claim Form A: Treatment Authorization

Sample (project-specific)

UNIVERSITY OF CALIFORNIA

Claim Form A:
Treatment Authorization

University of California
University Controlled Insurance Program

Campus / Medical Center:	
Project Name:	

Injured's Company Information:

Insurance Company, Billing Address:	Zurich WC Claims, 1400 American Lane, Schaumburg, IL 60196 phone: 877-928-4531; fa877-962-2567
Company's UCIP WC Policy Number:	
Injured's Company Name:	
Site Code:	
Contact Name:	
Contact Phone:	
Injured's Name:	
Date of Injury:	

☐ Authorization for work injury treatment.

☐ Authorization for Drug Screen "Non-DOT Quick Test".

Reason for drug test: ☐ Post-Accident ☐ For Cause

Comments:

Present this completed form to the medical provider's front desk.

Primary Treatment Facility:

[FACILITY NAME]
[FACILITY ADDRESS]
[FACILITY PHONE]
[FACILITY HOURS]

Emergency and After-Hours Treatment Facility:

[FACILITY NAME]
[FACILITY ADDRESS]
[FACILITY PHONE]
[FACILITY HOURS]

Willis

UCIP Administrator—1720 Post Road East, Suite 221—Westport, CT 06880
Toll-Free Phone: 877-277-1882—E-Mail: UC@mrmriskmanagement.com

8. Claim Form B: California Employer's Report of Occupational Injury or Illness (page 1 of 4)

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)

• 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.

FORM 5020 (Rev7) June 2002 — FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

OSHA CASE NO. | 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

Claim Form B: California Employer's Report of Occupational Injury or Illness (page 2 of 4)

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

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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

Claim Form B: California Employer's Report of Occupational Injury or Illness (page 3 of 4)

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

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**.

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Claim Form B: California Employer's Report of Occupational Injury or Illness (page 4 of 4)

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.

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.

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.

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.

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.*

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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*

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9. Claim Form C: General Liability Notice of Occurrence or Claim (page 1 of 2)

ACORD®

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?	

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Claim Form C: General Liability Notice of Occurrence or Claim (page 2 of 2)

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

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10. Sample Certificate of Insurance for Non-UCIP Coverage

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	See Section 4
B	AUTOMOBILE LIABILITY X ANY AUTO X ALL OWNED AUTOS X HIRED AUTOS SCHEDULED 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	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)

Policies above apply to operations in connection with [PROJECT NAME]. [GC NAME], 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 above general liability policies [pursuant to additional insured endorsement CG2010 (11/85) or a combination of both CG 2010 (10/01 or 07/04) and CG 2037 (10/01 or 07/04)] and automobile liability policies. 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 offsite only.**

CERTIFICATE HOLDER	CANCELLATION
The Regents of the University of California c/o Willis Insurance Services of California, Inc. Attn: UCIP Administrator 525 Market Street San Francisco, CA 94105	**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