SCORE

Small Cities Organized Risk Effort
A Joint Powers Authority

CLAIMS REPORTING MANUAL

FY 18/19

PRESENTED BY:
ALLIANT INSURANCE SERVICES
2180 HARVARD STREET STE 460
SACRAMENTO, CA 95815

VERSION 2.0

CLAIMS REPORTING MANUAL FY 18/19

Contents

SCORE Members Participation FY 18/19

MEMBER CITY	Liability	Property	CSAC EIA Pollution	Workers' Compensation	ERMA (EPL)	ACI EAP	Special Events	Crime (ACIP)	Crime (ID Fraud)	Alliant Mobile Vehicle (AMVP)	Contractor's Equipment (PEPIP)	Auto (PEPIP)	Vehicle Valuation (PEPIP)
Deductible		$5,000	$75,000		$25,000 $100,000*			$2,500 $25,000*	$0	$1,000 = X $2,000 = XX	$5,000* $10,000	$5,000* $10,000	
Biggs	X	X	X	X	X	X	X	X	X		X	X	ACV
Colfax	X	X	X	X	X	X	X	X	X		X	X	RC
Dunsmuir	X	X	X	X		X	X	X	X			X	Both ACV & RC
Etna	X	X		X		X	X		X	XX		X	ACV
Fort Jones	X	X	X	X		X	X		X			X	ACV
Isleton	X	X				X	X		X		X*	X*	RC
Live Oak	X	X	X	X	X	X	X	X	X			X	RC
Loomis	X	X	X	X	X	X	X	X	X	XX		X	ACV
Loyalton	X	X	X	X		X	X	X	X		X	X	RC
Montague	X	X	X	X			X	X	X		X	X	RC
Mount Shasta	X	X	X	X	X	X	X		X	XX		None	None
Portola	X	X	X	X	X	X	X		X	X	X	X	RC
Rio Dell	X	X	X	X	X		X	X	X		X	X	ACV
Shasta Lake	X	X	X	X	X	X	X	X	X		X	X	ACV
Susanville	X	X	X	X	X	X	X		X		X	X	RC
Tulelake	X	X	X	X	X	X	X		X			X	RC
Weed	X	X	X	X	X*	X	X	X*	X	XX	X	X	ACV
Yreka	X	X	X	X	X	X	X	X	X		X	X	RC

ERMA= Employment Risk Management Authority(Employment Practices Liability Coverage)
AMVP= Alliant Mobile Vehicle Program serviced by Marilyn Schley in SF office
Special Events serviced by Penny DeWitt in Newport Beach Office

SCORE MEMBER PARTICIPATION FY 18/19

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
Town Of Fort Jones
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

York Risk Services
PO Box 619079
Roseville, CA 95678

SCORE
Small Cities Organized Risk Effort
A Joint Powers Authority

Policy Period
July 1, 2018 –
June 30, 2019

Services Performed By:
York Risk Services
PO Box 619079
Roseville, CA 95678

Services Performed For:
Small Cities Organized Risk Effort
2180 Harvard Street STE 460
Sacramento, CA 95815

Liability Claims Contacts

ⓘ	***Cameron Dewey — Unit Manager, AIC, PCLA, LPCS*** ***Phone: 530-768-7385 Email: Cameron.dewey@yorkrsg.com***
ⓘ	***Craig Nunn — Senior Adjuster*** ***Phone: 530-768-4801 Email: craig.nunn@yorkrsg.com***
ⓘ	***York Answering Service*** ***Phone: 916-971-2701***
ⓘ	***Marcus Beverly — First Vice President, CPCU, AIC, ARM-P*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
ⓘ	***Michelle Minnick — Assistant Account Manager*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***

Client Responsibilities for Reporting Claims

ⓘ

- **All new losses should be sent to this email address as a first choice:**
  NCalYorkLiabilityClaims@yorkrsg.com
- Emergency or After Hours Calls

Cameron L. Dewey, Unit Manager	530-768-7385
Craig Nunn, Sr. Claims Representative	530-768-4801
York Answering Service	916-971-2701

- Be sure to include Alliant Program Administration Staff in communications with the Liability Claims Department.

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Sacramento, CA 95815

Workers' Compensation Claims Contacts

i	***Ariel Leonhard — Senior Claims Examiner*** ***Phone: 916-960-0974 Email: ariel.leonhard@yorkrsg.com***
i	***Teng Her — SIP, WCCP, Unit Manager*** ***Phone: 916-626-0842 Email: teng.her@yorkrsg.com***
i	***Dori Zumwalt — ARM, Senior Account Manager*** ***Phone: 916-960-1017 Email: Dorienne.zumwalt@yorkrsg.com***
i	***York Answering Service*** ***Phone: 916-971-2701 Fax: 866-548-2637***

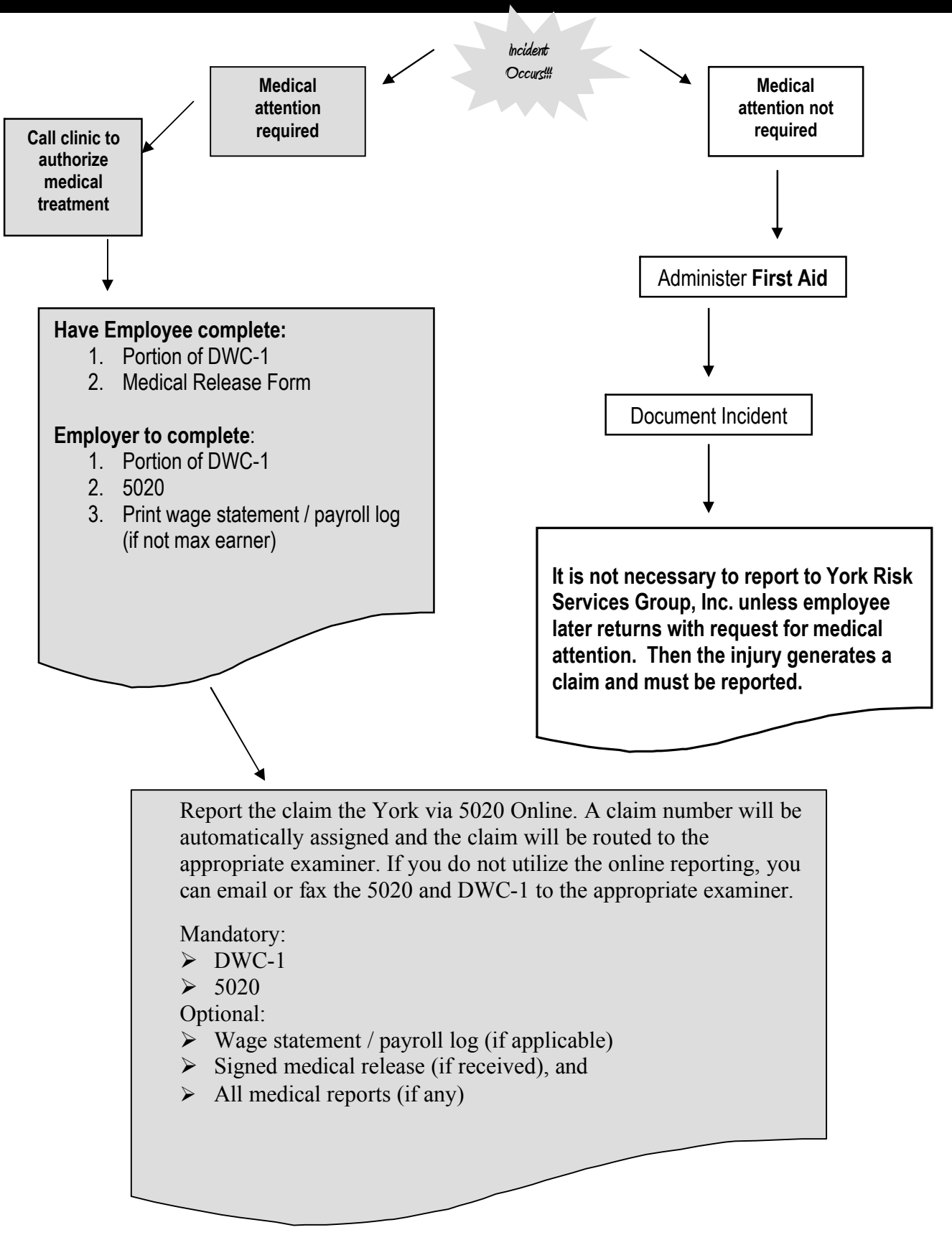
Client Responsibilities for Reporting Claims

i

- Supervisor should complete the following within 24 hours of knowledge of an injury or receipt of DWC-1 form:
  1. Bottom portion of DWC-1 lines 10-19 (Mandatory)
  2. Supervisor's Report of Injury
- The City or Town should complete the following within 24 hours of knowledge of an injury:
  1. Employer's Report of Injury, Form 5020 (Mandatory) either submit online via York 5020 Reporter or email to CASetupDesk@yorkrsg.com with a cc to ariel.leonhard@yorkrsg.com.
  2. Email or fax the DWC-1, Supervisor's Report, any medical reports or work status slips, or any other pertinent information to ariel.leonhard@yorkrsg.com or fax to 866-548-2637.
  3. Print wage statement / payroll log if requested from York.

*NOTE: To obtain a 5020 login, please go to the website, www.yorkrsg.com. Click on "Systems Login" and select "California 5020". Next you will select "Create a New Account." Our IT department will respond with your username and password to use with the online 5020 reporter.

WHAT TO DO WHEN AN INJURY OCCURS
INJURY FLOW CHART



WHAT TO DO WHEN AN INJURY OCCURS

FILLING OUT THE 5020
"EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS"

THIS FORM MUST BE COMPLETED AND MAILED TO YORK RISK SERVICES GROUP, INC. WITHIN FIVE DAYS OF ANY KNOWLEDGE OF INJURY/ILLNESS

1. The authorized employer representative must fill out the form as completely as possible.

    a) Questions 7 through 16 are for injured employee information. It is important that you include the injured employee's name, home address, social security number, date of birth, date of hire, employee status (permanent, temporary, volunteer), earnings, hourly rate and number of hours worked per week.

    b) Questions 17 through 26 are for dates of injury information. It is important that you include the date of injury, time the injury occurred, the dates the injured employee left work and returned, or if the injured employee is still off work.

    c) Question 17 is the same date that appears on line 11. "Date employer first knew of injury" of DWC-1 form.

    d) Question 18 is the same date that appears on line 12. "Date claim form was provided to employee" of DWC-1 form.

    e) Questions 19 through 29A request specific information regarding the injury and the treatment that was sought. Each of these lines on the form have an example that will help you make your explanation just as specific.

    f) Question 38, provide current gross wages/salary (for efficiency, please attach a wage statement/payroll log if possible).

    g) If any of these questions cannot be answered, write "unknown" in the blank.

2. Keep a copy of this form and mail the original and one of the copies to York Risk Services Group, Inc. within five days of knowledge.

By completing this form you are not admitting liability, but simply complying with the law. A sample form is attached.

Online 5020 Available!

Sign up to be able to complete the 5020 (Employer's Report) online at www.yorkrsg.com/ca5020.htm. Once you complete the sign up information it will take about 48 hours for your approval. You will be notified by e-mail once that approval has been processed and then you will be able to submit your 5020s online.

WHAT TO DO WHEN AN INJURY OCCURS
WORKERS' COMPENSATION CLAIMS REPORTING CHECKLIST

WHEN AN EMPLOYEE HAS A WORK-RELATED INJURY OR ILLNESS:

- Upon notice of the injury or illness, provide the injured employee with a DWC-1 Form "Employee's Claim for Workers' Compensation Benefits." This form must be mailed to the employee's mailing address if they are not present. **THIS FORM MUST BE PROVIDED TO THE INJURED WORKER WITHIN 24 HOURS OF NOTICE.** For instructions on filling out the DWC-1 Form, refer to page 5.

- Direct the injured worker to seek treatment at the employer designated medical facility unless the employee has completed a proper pre-designation physician form.

- Complete the 5020 Form "Employer's Report of Occupational Injury or Illness" and send it to York Risk Services Group, Inc. address listed on the "Who's Who in Claims" sheet. For instructions on filling out the 5020 Form, refer to page 12.

- Have the injured worker's supervisor complete your "Supervisor's Report of Employee Injury" form.

- Immediately report any serious injury to York Risk Services Group, Inc. by telephone.

TIME FRAMES: DWC-1: WITHIN 24 HOURS OF NOTICE OF INJURY
5020: WITHIN 5 DAYS OF NOTICE OF INJURY

If you have any questions regarding any of the steps in reporting a claim, please call your representative at York Risk Services Group, Inc.

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

To the Applicant: Please list the **names and addresses and phone numbers** of all doctors, hospitals and chiropractors you have seen within the past 5 years. This should include the name of your family doctor, any visits made to hospitals and clinics (even emergency visits) and the name of any other physicians or chiropractors you have seen. If you can remember the year that you were seen by these individuals, please also list. If you have been treated at a Kaiser facility, please specify the location and include your medical record number. **Please date and sign the attached authorization to release medical records or information.**

YOUR FAMILY DOCTOR:

NAME, ADDRESS, PHONE NUMBERS AND BODY PART(S)

_____

_____

_____

HOSPITALS AND CLINICS:

NAME, ADDRESS, PHONE NUMBERS AND BODY PART(S)

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

CHIROPRACTORS:

NAME, ADDRESS, PHONE NUMBERS AND BODY PART(S)

1._____

_____

_____

2. _____

_____

_____

ANY OTHER PHYSICIANS:

NAME, ADDRESS, PHONE NUMBERS AND BODY PART(S)

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

4. _____

_____

_____

5. _____

_____

_____

6. _____

_____

_____

7. _____

_____

_____

Date _____ Signature X_____

☐ **List of authorized persons or class of persons on Page 1 of 3 attached herein by reference.**

☐ _____

☒ Functions/Class **All providers of health care, health care service plan, pharmaceutical company, or contractor that may disclose the medical information.**

AUTHORIZATION TO RELEASE MEDICAL RECORDS OR INFORMATION

I, the undersigned, authorize the above-named provider(s) of services to release to: York Risk Services Group, Inc., their authorized agent Castle Copy Service, _____, attorneys, doctors, examiners or other classes of people that will evaluate your claim, all personal health information (PHI) as described; medical records, charts, notations, correspondence, reports, photographs, films, except as specifically excluded below:

_____

or, only the following records or types of health information and /or only on the specified dates:

Dates(s) of Treatment: _____

Type of Treatment: _____

All employment records, to include but not limited to: Personnel file, attendance record, employment records, medical and insurance records and wage records.

All medical records from Social Security Administration.

All scholastic records, to include but not limited to: Attendance records, records regarding disciplinary action or infractions, medical records and transcripts.

All insurance claims files for the undersigned dealing with prior, present and subsequent claims for injuries and/or damages.

The disclosure of records authorized herein is required for the following purpose only:

For administration of your Workers Compensation Claim

This authorization shall become effective immediately and shall remain in effect as long as is necessary for York Risk Services Group, Inc. to administer your

Workers Compensation Claim, but nevertheless shall expire 1 year from the date of your signature.

This is an informed consent for the release of my records, and I have a right to receive a copy of this authorization upon request. A photocopy of this signed authorization shall be deemed as valid as the original.

I understand that such information may be re-released to other parties necessary to participate in processing my claim. If my PHI is released to recipient(s) that are not subject to the federal confidentiality law, it may no longer be protected.

I have asked questions about anything that was not clear to me, and I am satisfied with the answers received.

This consent is subject to revocation by the undersigned in writing at any time by sending revocation to York Risk Services Group, Inc. and to the list of care providers listed on page 1, except to the extent that action has been taken in reliance herein, and if not earlier revoked, it shall terminate on the conclusion of my case without express revocation. If I revoke this authorization, it will not have any affect on actions taken by all parties in reliance of it before I revoked it.

I acknowledge that I am aware that the consequences of my not signing this authorization can include a delay in the processing/resolution of the (my) claim, a potential denial of the claim, or other consequences recognized by applicable state law and /or the insurance policy at Issue. The healthcare facility will not condition treatment upon securing a signed authorization.

Dated: _____ _____

(Signature)

_____ _____

(Name and relationship of party other than patient signing) (Patient Name)

_____

(Date of Birth)

I hereby also specifically consent to the release of any and all alcohol, drug abuse, or psychiatric treatment records under the same conditions at outlined above.

Date _____ Signature _____

WHAT TO DO WHEN AN INJURY OCCURS

FILLING OUT THE DWC-1 FORM
"EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS"

THIS FORM MUST BE PROVIDED TO THE INJURED WORKER WITHIN 24 HOURS OF <u>ANY</u> KNOWLEDGE OF INJURY/ILLNESS

1. The authorized employer representative must complete the bottom Employer section before giving or mailing the form to the employee.
   a) Do not fill in line 13 until the form is returned by the employee.
   b) Fill in lines 9, 10, 14, 15, 17 & 18.
   c) Fill in line 11 with the date when the employer first knew of the injury/illness.
   d) Fill in line 12 with the date that the claim form was given or mailed to employee. The form should not be given out in advance.
   e) Sign the form on line 16 after filling out the form.

2. Tear off and keep a copy as your temporary receipt. Mail a copy of the temporary receipt to York Risk Services Group, Inc. if the injured employee does not fill out the form on that day.

3. If the injured employee is not present, you must mail the form to him/her. If the injured employee is present, give the partially completed form to him/her with the instruction to fill out the top Employee section.

4. When providing DWC-1 to employee please provide an authorization to Release Medical Records form (sample attached).

5. Within 24 hours of receiving this form back from the injured worker:
   a) Fill in line 13 with the date that the form was received from the employee.
   b) Give a completed copy to the employee.
   c) <u>Within 24 hours, mail a completed copy to York Risk Services Group, Inc</u>.

<u>By completing this form you are not admitting liability, but simply complying with the law</u>. Failure to provide this form within 24 hours of knowledge of an injury could result in a $100 fine. Failure to provide this form within 24 hours of request could result in a $5,000 fine. A sample form is attached.

REQUIRED FORMS/NOTICES FOR ALL EMPLOYEES

NEW EMPLOYEE PAMPHLET
(FACTS ABOUT WORKERS' COMPENSATION)

YOU ARE REQUIRED TO PROVIDE INFORMATION ABOUT RIGHTS, BENEFITS AND OBLIGATIONS OF WORKERS' COMPENSATION TO EVERY NEW EMPLOYEE

Labor Code Section 3551 states that every employer shall provide to every new employee, either at the time of hire or no later than the end of the first pay period, information concerning the rights, benefits and obligations under workers' compensation laws.

The pamphlet shall be in writing, in non-technical terms and shall include information regarding the scope of coverage, their rights to medical care, indemnity benefits and vocational rehabilitation, the procedures for reporting accidents and injuries, and where additional information can be obtained.

York Risk Services Group, Inc. is happy to assist you in obtaining a supply of pamphlets. A sample pamphlet is attached.

Pre-designation Of Personal Physician

In the event you sustain an injury or illness related to your employment, you may be treated for such injury/illness by your personal medical doctor (M.D) or doctor of osteopathic medicine (D.O.) or medical group if: You have health care insurance for injuries/illness that are not work related, the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records; your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries; prior to the injury your doctor agrees to treat you for work injuries or illnesses; prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury/illness, and (2) your personal doctor's name and business address.

You may use this form, a form provided by your employer or provide all the information in writing to notify your employer if you wish to have your personal medical doctor or a doctor osteopathic medicine treat you for a work-related injury/illness and the above requirements are met.

Notice Of Pre-designation Of Personal Physician
Employee: Complete this section

Employer _____

If I have a work-related injury or illness, I choose to be treated by:

_____
(Name of doctor) (M.D., D.O., or medical group)

_____
(street address, city, state, zip)

_____
(telephone number)

Employee Name (please print): _____

Employee's Address:_____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses: _____

_____

Employee Signature:_____Date_____

Note to Employee: Unless you agree in writing, neither your employer or York may contact your personal physician to confirm a pre-designation. If your physician does not sign this form, other documentation that they agreed to be pre-designated prior to the injury will be required. If you agree, your employer or York may contact your personal physician to confirm this pre-designation, sign and date below:

Employee Signature_____

Employee #_____ Date_____

Physician: I agree to this Pre-designation:

Signature:_____Date_____

(Physician or Designated Employee of the Physician)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3). (Optional DWC Form 9783 July 1, 2014)

Notice Of Personal Chiropractic Or Personal Acupuncturist

If your employer or your employer's insurer does not have a Medical Provider Network (MPN), you may be able to change your treating physician to your personal chiropractor (D.C.) or acupuncturist (L.AC.) following a work-related injury/illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal D.C. or L.AC. in writing prior to the injury/illness. York generally has the right to select your treating physician within the first 30 days after your employer knows of your injury/illness. After your employer or York has initiated your treatment with another physician during this period, you may then, upon request, have your treatment transferred to your personal D.C. or L.AC. You may use this form to notify your employer of your personal D.C. or L.AC., or your employer may have their own form. The D.C. or L.AC. must be your regular D.C. or L.AC. who has directed your treatment and retains your chiropractic records and history. If your employer has an MPN, you may only switch to a D.C. or L.AC. within the MPN. A chiropractor cannot be your treating physician after 24 visits. If you still require medical treatment thereafter, you will have to select a physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

_____ _____
Name of chiropractor or acupuncturist (D.C., L.AC.)

_____
(street address, city, state, zip code)

_____
(telephone number)

Employee Name (Please Print):_____

Employee's Address:_____

_____

Employee's Signature:_____

Date:_____

Title 8, California Code of Regulations, section 9783.1
(Optional DWC Form 9783.1 Effective date July 1, 2014)

WHEN A WORK INJURY OCCURS…

- **Quickly seek first aid.**
- **Call 9-1-1 for help immediately if emergency medical care is needed.**
- **Immediately report injuries to your supervisor or employer representative at** _____

_____

Information & Assistance Office:_____

_____

_____

Employer MUST complete this information

YORK™
Risk Services Group

The Facts About Workers' Compensation

York Risk Services Group, Inc.
P.O. Box 619079
Roseville, CA 95661
Phone (866) 221-2402
Fax (866) 548-2637

Approved by Division of Workers' Compensation

What is workers' compensation? Its purpose is to insure that an employee who is found to sustain an industrial injury or illness will be provided with benefits to medically cure or relieve them from the effects of the injury/illness, provide temporary compensation when they are medically unable to perform any occupational function, compensation for any residual handicap and/or impairment of bodily function, benefits for dependents if an employee dies as a result of an injury/illness, protection from discrimination by his/her employer because of the injury/illness.

Am I Covered? Nearly every person employed in California is protected by workers' compensation, however there are a few exceptions. People that are self-employed or volunteer workers may not be covered. Similar laws cover federal and maritime workers. York Risk Services Group (York) is your employer's claims administrator. Your employer or York can answer any questions you might have about coverage.

What Does Workers' Compensation Cover? If you have an injury/illness due to your job, it is covered. The cause can be a single event, like a fall or it can be due to repeated exposures, such as hearing loss due to constant loud noise. Injuries ranging from first-aid to serious accidents are covered. Even injuries related to a workplace crime, such as psychological or physical injuries, are covered under workers' compensation. Some injuries that result from voluntary activity, such as off duty social or athletic activities may not be covered. Check with your employer or York if you have questions. Coverage begins the moment you start your job. There is no probationary period or wage rate.

Duty Of The Employee. Immediately notify your employer or York so you can get the medical help that you need without delay. If your injury is greater than a first-aid injury, your supervisor will give you a Claim Form (Form DWC-1) for you to describe where, when and how it happened. To submit a claim, fill out the "Employee" section of the DWC-1. Keep one copy of this form and give the remaining pages to your supervisor. Your employer will fill out the "Employer" section and return a signed and dated copy of the form to you. Your employer will keep a copy of this form and forward another to York. York is in charge of handling your claim and informing you about your eligibility for benefits.

Your claim benefits do not start until your employer knows about your injury, so report and file the DWC-1 as quickly as possible. California law requires your employer to authorize medical treatment within one working day of receipt of your Claim Form. Employers are liable for up to $10,000 in treatment pending a decision by York for a claim to be accepted or rejected. Waiting to report may delay workers' compensation benefits. You may not receive benefits if you fail to file a claim within one year of the date of injury, the date you know the injury was work related, or the date benefits were last provided.

Duty of the Employer: Provide this form to every employee at the time of hire or by the end of their first pay period.

Within one working day, upon knowledge or notice from any source of a work injury/illness greater than first-aid, provide the employee with a Claim Form (DWC-1) and authorize medical treatment and report the claim to York Risk Services Group.

What are the benefits? You may be entitled to various kinds of benefits under California workers' compensation law including:

Medical Care: Medical treatment that is reasonably required to cure or relieve the injured worker from the effects of the injury/illness. There is no deductible or co-payment. These medical benefits may include lab tests, physical therapy, hospital services, medication and treatment by a doctor.

State law limits certain medical services as of January 1, 2004. You should never receive a medical bill. If additional treatment is necessary, York will coordinate medical care that meets applicable treatment guidelines for the injury. The doctor may be a specialist for your specific type of injury, and he or she will be familiar with workers' compensation requirements and will report promptly to York so your benefits can be paid.

The physician with overall responsibility for treating your injury/illness is your primary treating physician (PTP). The PTP decides what kind of medical care you need and if you have work restrictions. If necessary, the PTP will review your job description with you and your employer to define any limitation or restrictions that you may have. This doctor also is responsible for coordinating care between other medical providers and will write reports about any permanent impairment of bodily function(s) or the need for future medical care. Generally, your employer selects the PTP you will see for the first 30 days, but if you want to change doctors for any reason, ask your employer or York. They're as interested as you are in your prompt recovery and return to work and will select a different doctor for you. If your employer has a Medical Provider Network (MPN) you will be directed to treat with a physician within the MPN and different rules apply regarding changing your physician.

You can be treated by your personal physician or medical group immediately if you have health care insurance for injuries or illness that are not work related, and your physician agrees in advance to treat you for any work injuries/illnesses and has previously directed your treatment and retains your medical records and agrees, prior to your injury/illness, to treat you for workplace injuries/illnesses and you gave your employer your physician's name and address in writing before the injury. You may use the form inside of this pamphlet or your employer may have a form for you to use.

If you give the name of your personal chiropractor or acupuncturist, different rules apply, and you may need to see an employer-selected physician first.

Temporary Disability Benefits: If you are not medically able to work for more than three days due to your work-related injury, counting weekends, you have a right to temporary disability (TD) payments to assist substituting your lost wages. After two weeks from reporting the injury, you will receive a check. If your employer has a salary continuation plan, your benefit may be included in your regular paycheck. TD is payable every 14 days until the doctor states you can return to work (Payments won't be made for the first three days, though, unless you're hospitalized as an inpatient or unable to work more than 14 days). The amount of the payments will be two-thirds of your average wage, subject to minimums and maximums set by the state legislature. Although the TD payment will not be the full amount of your regular paycheck, there are no deductions and the payments are tax-free. For injuries occurring on or after January 1, 2008, TD payments are limited to 104 compensable weeks within five years of date of injury. For a few long-term injuries such as chronic lung disease or severe burns, TD payments can last up to 240 weeks within five years from the date of injury. If you reach the maximum TD payment period before you can return to work or before your condition becomes permanent and stationary. See the "Other Benefits" section of this pamphlet for additional in information. A timely filing with Employment Development Department may result in additional State Disability benefits when TD benefits are delayed, denied, or terminated.

Permanent Disability: If your doctor says your injury will always leave you with some permanent impairment of bodily function(s), you may receive permanent disability (PD) payments. The amount depends on the doctor's report, how much of the PD was directly caused by your work, and factors such as your age, occupation, type of injury, and date of injury. State law determines minimum and maximum amounts, and they vary by injury date. If you are entitled to PD, York will send you a letter explaining how the benefit was calculated. If the injury causes PD, the first payment of PD benefits is made within 14 days after the last payment of TD, unless your employer has offered you a position that pays at least 85% of your date of injury wages or if you are returned to a position that pays you 100% of the wages and, compensation paid to you on the date of injury, the PD would be paid after an Award issues.

Supplemental Job Displacement Benefit (SJDB): If you have a permanent whole person impairment, the eligibility for SJDB begins when your employer does not offer regular work, permanent, modified, or alternative work within 60 days of the receipt of a doctor's Medical Maximum Improvement (MMI) report. This is a nontransferable voucher for education-related retraining and/or skill development at state-approved schools, tools, licensing, certification fees and other resources as possible benefits. If you qualify for the supplemental job displacement benefit, York will provide a voucher up to a maximum of $6,000.

Death Benefits: If the injury/illness causes death, payments may be made to your dependents. State law sets these benefits and the total benefit depends on the number of dependents. The payments are made at the same rate as TD payments. In addition, workers' compensation provides a burial allowance.

Discrimination: It a violation of Labor Code Section 132(a) and illegal for your employer to punish or fire you for having a workplace injury/illness, for filing a claim or for testifying in another person's workers' compensation case. If your employer is found guilty of discrimination, you would be entitled to increased benefits, reinstatement and reimbursement for lost wages and benefits.

Other Benefits: Sometimes people confuse workers' compensation with State Disability Insurance (SDI). Workers' compensation covers on-the-job injuries/ illnesses and is paid for by your employer or their insurance. On the other hand, SDI covers off-the-job injuries or sicknesses, and is paid for by deductions from your paycheck. If you are not getting workers' compensation benefits, you may be able to get State Disability benefits. Contact the local office of the State Employment Development Department listed in the government pages of your phone book for more information.

You may be eligible to access the return-to-work fund, for the purposes of making supplemental payments to injured worker's whose PD benefits are disproportionately low in comparison to their earnings loss. If you have questions or think you qualify, contact the Information & Assistance office listed in this pamphlet or visit the DIR website at: www.dir.ca.gov.

If You Still Have Questions…ask your supervisor or employer representative. Or contact York at the number indicated on workers' compensation posters at work and on this brochure. You can also contact the State Division of Workers' Compensation (DWC) and speak with an Information and Assistance Officer. These officers are available to review problems, answer questions and provide additional written information about workers' compensation at no charge. The local office is listed below and posted at your workplace. You can also call 800-736-7401 or visit the DWC website at: http://www.dir.ca.gov/dwc.

WORKERS' COMPENSATION FRAUD IS A FELONY

Anyone who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. Fines can be up to $150,000 and imprisonment up to five years.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

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

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

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

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.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

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

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

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

6/10 Rev.

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

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments 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 NJURY 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 INJURYIILLNESS, 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 WAGESISALARY (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.

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

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

GLOSSARY OF TERMS

The claims process is complex and strictly regulated. In this section you will see a variety of acronyms and terms. Here are some definitions:

WHO

AA	Applicant Attorney
DA	Defense Attorney
EE	Employee
ER	Employer
Dist. Atty.	District Attorney

GENERAL

DOI	Date of Injury
AWW	Average Weekly Wage
DEU	Disability Evaluation Unit
DWC-1	Employee Claim Form
5020	Employer's Report of Injury
5021	Doctor's First Report of Injury
AOE/COE	Arising out of employment/in the course of employment
DOB	Date of Birth
MOD DUTY	The injured worker is released to work with physical/mental restrictions
NLT	No lost time
RTW	Return to Work
Three point contact	At the onset of a new loss, York will contact the employer, injured worker and the doctor

MEDICAL TERMS

ACOEM	American College of Occupational and Environmental Medicine
AME	Agreed Medical Examiner (applicant and defense agree to use one doctor)
AQME	The applicant's choice of Qualified Medical Examiner
DQME	Defendant's choice of medical evaluation once they have objected
DX:	Diagnosis
FOV	First office visit
HX	Medical history
LOV	Last office visit
MMI	Maximum medical improvement. The recovery of an injury has stabilized and recovery is maximized. The claim is poised for a permanent disability rating. Same as permanent and stationary
NOV	Next office visit
OBJECT	Examiner objects to medical treatment and offers AME/QME or panel QME
P & S	Permanent and stationary

GLOSSARY OF TERMS (cont'd)

PQME	When claimant is not represented by an attorney and either party objects, the claimant goes through a State Panel Qualified Medical Evaluation
SX	Surgery
PTP	Treating physician
UR	Utilization Review
DC	Chiropractor
PT	Physical Therapy
TREATER	Treating physician

LEGAL TERMS

APP	The legal filing that initiates litigation in the Workers' Compensation system
C & R	Compromise and Release
DOR	Declaration of Readiness to Proceed (This assigns a court date)
132(a)	Labor Code section that allows employees to petition for penalties against the employer for discriminating against an employee because they had a workers' compensation injury.
In Pro Per	Claimant is not represented by an attorney
F & A	Findings and Award
F & S	File and serve the document on the parties
MSC	Mandatory Settlement Conference
L.C.	Labor Code
PTC	Pre Trial Conference
S & A	Stipulations with Request for Award
S & W	Serious and Willful Misconduct. Penalty claims filed as a result of injury from willful violations of enforced safety policy. Employer knew of negligence on premises or faulty property, did not fix it and the employee sues for this in workers compensation arena
SUBRO	Subrogation (third party recovery)
WCAB	Workers Compensation Appeals Board
WCJ	Workers Compensation Judge

INVESTIGATION

SUBROSA	Obtaining investigation film on a person

BENEFIT TERMS

PPD	Permanent partial disability (we usually say pd)
PTD	Permanent total disability (100%)
TTD	Temporarily total disability (we usually say td)
TPD	Temporarily partial disability (modified duty or wage loss)
LP	Life pension

GLOSSARY OF TERMS (cont'd)

VOCATIONAL REHABILITATION

Voc Rehab or VR	Vocational Rehabilitation
QIW	Qualified Injured Worker (for vocational rehabilitation)
VRMA	Vocational rehabilitation maintenance allowance
MOD ALT	The injured worker is QIW and the employer offers permanent modified duty
SJD	Supplemental job displacement. Vocational rehabilitation benefit

Remember:

Exacerbation	A temporary increase of a pre-existing symptom. (Not a new injury)
Aggravation	An injury whose symptoms have been indefinitely made worse and/or the symptoms have increased dramatically. (A new injury to be reported, if not first aid)

REQUIRED FORMS/NOTICES FOR ALL EMPLOYEES
EMPLOYEE'S DESIGNATION OF PERSONAL PHYSICIAN

Under Labor Code 4600 and 4601, the employee is required to inform his/her employer in writing prior to the workers' compensation injury, if the injured employee chooses to be treated by his/her personal physician. Pre-designations completed previous to the April 19, 2004 workers' compensation reform may be invalid as the following criteria must be met in order to be currently effective:

- The personal physician the employee selects must be his/her "regular physician and/or surgeon" who has his/her medical record file and history. The physician has to have previously directed his/her medical treatment.

- The employee's personal physician must be a medical doctor. Employees are no longer allowed to select a chiropractor or acupuncturist as your personal physician.

- The personal physician selected must be a part of the employer's non-occupation group coverage.

- The personal physician selected MUST agree to being pre-designated by the employer AND comply with workers' compensation laws and reporting requirements.

There is no required format for the pre-designation form that you must provide the employee. A sample form is attached.

To All Employees:

RE: New Procedure in Workers' Compensation for Pre-Designation of Your Personal Physician.

As of April 19, 2004, the California Legislature enacted Senate Bill 899. This bill has changed the rules for pre-designating a personal physician to provide treatment for injuries that occur on the job. As a result of this change in the law, all previous pre-designations of personal physicians may no longer be valid.

Under the new law, all pre-designations of a personal physician MUST meet ALL of the following requirements found in Labor Code Section 4600(d)(1) which indicates:

1. The personal physician you select must be your "regular physician and/or surgeon" who has your medical record file and history. The physician has to have previously directed your medical treatment.

2. Your personal physician must be a medical doctor. You are no longer allowed to select a chiropractor or acupuncturist as your personal physician.

3. The personal physician you select must be a part of the employer's non-occupation group coverage.

4. The personal physician you select MUST agree to being pre-designated by you AND comply with workers' compensation laws and reporting requirements.

If you wish to designate a personal physician to treat you in the event of a workers' compensation injury, please complete the new pre-designation form that is attached. This form must be signed by you AND your personal physician and returned to your supervisor and/or human resources department BEFORE an injury occurs, to be valid.

Please be advised that if you DO NOT wish to pre-designate a treating physician, you must seek treatment at the employer's designated facility for the first 30 days of your claim. In the event you have selected a new personal physician, but wish to seek treatment at the employer's designated facility, you may do so.

If you wish to designate a personal physician to treat you in the event of a workers' compensation injury, please complete the new pre-designation form and have your pre-designated physician complete and sign the Certification of Physician. You will need to return both forms to your employer.

PRE-INJURY PERSONAL PHYSICIAN PRE-DESIGNATION FOR WORK RELATED INJURIES

Date employee was provided Pre-Designation Form: _____

Employee Name:_____
Employee Address:_____
City, State and ZIP Code:_____
Employer Name:_____
Employer Address and Department:_____
Private Health Insurance Coverage:_____
Private Health Insurance Address:_____
Private Health Insurance Telephone Number:_____
Private Health Insurance Medical Record/Group Number:_____

I understand the Workers' Compensation Laws of the State of California indicate that if I have notified my employer in writing prior to the date of injury that I have a personal physician, I shall have the right to be treated by such physician from the date of injury. As defined by law, a "personal physician" must be the employee's regular physician and/or surgeon who has your medical record file and history; must be the employee's primary care physician who has previously directed the medical treatment; must be a medical doctor and not a chiropractor or acupuncturist; must be a part of the employer's non-occupation group coverage and MUST agree to be pre-designated AND comply with workers' compensation laws and reporting requirements. If I am injured on the job, I would like to be treated by the physician whose information is provided below. I verify by signing below that the below physician meets the above legal requirements.

I understand that my employer requires me to contact the below physician who must sign the attached form to prove he agrees to treat me in the event of an injury on the job and also prove he will abide and adhere to Title 8, California Code of Regulations 9785, the Reporting Duties of the Primary Treating Physician and Labor Code 4610. I further understand that I am responsible for signing the below document and seeking agreement and signature of the attached document from my personal physician and I am to return all of the documents to my employer. If all of these steps do not occur, I am aware my pre-designation form is invalid. If my employer does not have this completed form prior to industrial injury, I will seek medical treatment with the employer's designated medical facility as noted on the posted notices regarding workers' compensation.

Even though I am designating a personal physician, I understand that my employer may require me to undergo medical examinations by other physicians at their request and expense.

Physician's Name:_____
Physician's Street Address:_____
Physician's City, State and ZIP code:_____
Physician's Telephone Number:_____
Medical Specialty:_____

I understand that the filing of this form does not relieve me from my obligation to report all injuries immediately to my supervisor and to complete all required reporting forms. I certify that all of the above statements are true and correct to the best of my knowledge.

Employee Signature:_____
Employee Name (print):_____
Date of Request:_____

This form must be signed by you AND your personal physician. You must return ALL of the signed documents to your supervisor and/or human resources department BEFORE an injury occurs, to be valid.

RE: Workers' Compensation medical treatment certification

Dear Dr. _____:

The employee listed on the reverse side of this document has selected you as a pre-designated physician for work related injuries. For your convenience, the employer has provided a copy of the regulations required of a primary treating physician for treating a patient who is industrially injured. As such, please verify the following information.

CERTIFICATION OF PHYSICIAN

This is to certify I am the above patient's regular, primary care physician. I have treated him/her for non-work related medical problems and I maintain his/her medical records in my office.

I have read and agree with the Reporting Duties of the Primary Treating Physician, per California Code of Regulations, Title 8, Section 9785 that is attached to this document and agree to abide by the laws when treating this employee for work-related injuries or illnesses.

I acknowledge all requests for medical care will be governed by Labor Code 4610 outlining mandatory utilization review under the guidelines of the American College of Occupational and Environmental Medicine (ACOEM).

In addition, I agree to accept payment for medical treatment services provided in accordance with the California Official Medical Fee Schedule.

Physician's Signature: _____

Print Name: _____

Date: _____

I decline the request to be his/her Treating Physician for work-related injuries.

Physician's Signature:_____

Print Name: _____

Date:_____

CALIFORNIA CODE OF REGULATIONS,
Title 8, Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director—Administrative Rules
Article 5. Transfer of Medical Treatment
Section §9785. Reporting Duties of the Primary Treating Physician

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(a) For the purposes of this section, the following definitions apply:

(1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer or the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code.

(2) A "secondary physician" is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.

(3) "Claims administrator" is a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(4) "Medical determination" means, for the purpose of this section, a decision made by the primary treating physician regarding any and all medical issues necessary to determine the employee's eligibility for compensation. Such issues include but are not limited to the scope and extent of an employee's continuing medical treatment, the decision whether to release the employee from care, the point in time at which the employee has reached permanent and stationary status, and the necessity for future medical treatment.

(5) "Released from care" means a determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.

(6) "Continuing medical treatment" is occurring or presently planned treatment that is reasonably required to cure or relieve the employee from the effects of the injury.

(7) "Future medical treatment" is treatment, which is anticipated at some time in the future and is reasonably required to cure or relieve the employee from the effects of the injury.

(8) "Permanent and stationary status" is the point in time, determined by the primary treating physician, when the employee has reached maximum medical improvement or his or her condition has been stationary for a reasonable period of time.

(b)(1) An employee shall have no more than one primary treating physician at a time.

(2) An employee may designate a new primary treating physician of his or her choice pursuant to Labor Code §§4600 or 4600.3 provided the primary treating physician has determined that there is a need for:

(A) continuing medical treatment; or

(B) future medical treatment. The employee may designate a new primary treating physician to render future medical treatment either prior to or at the time such treatment becomes necessary.

(3) If the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, the dispute shall be resolved under the applicable procedures set forth at Labor Code §§4061 and 4062. No other primary treating physician shall be designated by the employee unless and until the dispute is resolved.

(4) If the claims administrator disputes a medical determination made by the primary treating physician, the dispute shall be resolved under the applicable procedures set forth at Labor Code §§4061 and 4062. During the course of such procedures, and provided the primary treating physician has determined that there is a need for continuing or future treatment, the employee may designate a new primary treating physician of his or her choice pursuant to Labor Code §§4600 or 4600.3 to render treatment.

(c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of its copy of the required report.

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subdivisions (e), (f) and (g) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subdivisions (e), (f) and (g) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

(e)(1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness," Form DLSR 5021. Emergency and urgent care physicians shall also submit a Form DLSR 5021 to the claims administrator following the initial visit to the treatment facility. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture).

(2) Each new primary treating physician shall submit a Form DLSR 5021 following the initial examination in accordance with subdivision (e)(1).

(3) Secondary physicians, physical therapists, and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

(4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

(f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:

(1) The employee's condition undergoes a previously unexpected significant change;

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

(3) The employee's condition permits return to modified or regular work;

(4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications;

(5) The employee is released from care;
(6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury, as required pursuant to Labor Code Section 4636(b);

(7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207.

(8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination.

Except for a response to a request for information made pursuant to subdivision (f)(7), reports required under this subdivision shall be submitted on the "Primary Treating Physician's Progress Report" form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled "Primary Treating Physician's Progress Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code §139.3."

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(g) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the "Primary Treating Physician's Permanent and Stationary Report" form (Form PR-3) contained in Section 9785.3, or using the instructions on the form entitled "Treating Physician's Determination of Medical Issues Form," Form IMC 81556, or in such other manner as provides all the information required by Title 8, California Code of Regulations, Section 10606. Qualified Medical Evaluators and Agreed Medical Evaluators may not use Form PR-3 to report medical-legal evaluations.

(h) Any controversies concerning this section shall be resolved pursuant to Labor Code Section 4603 or 4604, whichever is appropriate.

(i) Claims administrators shall reimburse primary treating physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule.

REQUIRED FORMS/NOTICES FOR ALL EMPLOYEES
POSTING NOTICE INSTRUCTIONS

YOU ARE REQUIRED TO POST A NOTICE ON WORKERS' COMPENSATION IN A CONSPICUOUS LOCATION

Labor Code Section 3550 states that every employer shall post and keep posted in a conspicuous location frequented by employees, and where the notice may be easily read by employees during the hours of the workday, a notice which shall state that the employer is self-insured and the name of the claims administrator.

Failure to post required notices is a misdemeanor and shall automatically permit the employee to be treated by their personal physician with respect to an injury occurring during that failure.

The posters are just one way of communicating to your employees the location of the pre-designated treatment facility. It can also notify the employee who to contact to report their injury.

York Risk Services Group, Inc. is happy to assist you in obtaining the proper posters. A sample form is attached.

STATE OF CALIFORNIA - DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

Notice to Employees--Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. There is a limit on some medical services.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if your injury causes a permanent disability.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher payable to a state approved school if your injury arises on or after 1/1/04 and results in a permanent disability that prevents you from returning to work within 60 days after TD ends, and your employer does not offer you modified or alternative work.
- **Death Benefits:** Paid to dependents of a worker who dies from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group *before* you are injured and your physician must agree to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.

2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury. 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 your alleged injury and shall be liable for up to ten thousand dollars ($10,000) in treatment until the claim is accepted or rejected.

3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness. If you predesignated by naming your personal physician or medical group before injury (see above), you may see him or her for treatment in certain circumstances. Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days. Different rules apply if your employer offers a Health Care Organization (HCO) or has a Medical Provider Network (MPN). You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.

4. **Medical Provider Networks.** Your employer may be using a MPN, which is a selected network of health care providers to provide treatment to workers injured on the job. If your employer is using a MPN, a MPN notice should be posted next to this poster to explain how to use the MPN. You can request a copy of this notice by calling the MPN number below. **If you have predesignated a personal physician prior to your work injury, then you may receive treatment from your predesignated doctor.** If you have not predesignated and your employer is using a MPN, you are free to choose an appropriate provider from the MPN list after the first medical visit directed by your employer. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

Current MPN's toll free number: _____ MPN website: _____

MPN Effective Date_____ Current MPN's address: _____

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

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator _____ Phone _____

Workers' compensation insurer _____ (Enter "self-insured" if appropriate)

Policy Expiration Date _____

If the workers' compensation policy has expired, contact a Labor Commissioner at the Division of Labor Standards Enforcement (DLSE).

You can also get free information from a State Division of Workers' Compensation Information & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401**. Learn more information about DWC and DLSE online: **www.dwc.ca.gov or www.dir.ca.gov/dlse.**

False claims and false denials. 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 and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
División de Compensación de Trabajadores

Aviso a los Empleados—Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo el lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por mas de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesione y su médico debe estar de acuerdo de atenderle la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.

2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dolares ($10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.

3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.

4. Red de Proveedores Médicos (MPN): Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su medico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguente información del contacto de la MPN :

Número gratuito de la MPN vigente:_____ Página web de la MPN:_____

Fecha de vigencia de la MPN _____ Dirección de la MPN vigente _____

Discriminación. 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. 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.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contratado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos _____ Teléfono _____

Asegurador del Seguro de Compensación de trabajador _____ (Anote "autoasegurado" si es apropiado)

Fecha de Vencimiento de la Póliza _____

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores.

El Oficial de Información y Asistencia más cercano se localiza en _____

o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: **www.dwc.ca.gov o www.dir.ca.gov/dlse.**

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

FREQUENTLY ASKED QUESTIONS (FAQ's)

If you have specific questions about the workers' compensation process that are not covered by the following information, please call your representative at York Risk Services Group, Inc.

A. How does the workers' comp process begin?

The process begins when the employer is made aware of an injury, illness, or death of an employee that is the result of the employee's work.

B. What constitutes notice of a workers' comp claim?

A claim is created when an employee suffers a work-related injury, illness, or death and the employer is notified by one of the following:

- Employee tells supervisor of the incident;
- Employee tells another employee of the incident;
- Another employee observes injury and tells supervisor of the incident;
- Employee's supervisor observes an incident;
- The employee's legal representative files a claim with the employer.

C. When knowledge of injury/illness is received, what are the paperwork steps?

1. If there is no lost time and no doctor visit:
   - Employer's internal accident/incident report should be completed within 48 hours of knowledge, to be kept in the supervisor's personnel file.
   - If requested by the injured employee, the workers' comp Employee Claim Form (DWC-1) should be provided to the employee within 24 hours of the Request (provided by mail or in person) with verification this has been done through a "Proof of Service" form or other formal verification process.

2. If there is lost time and/or a doctor's visit:
   - Employer's accident/incident report should be completed within 48 hours of knowledge.
   - Employee Claim Form should be provided to injured employee within 24 hours of knowledge of injury (provided by mail or in person) with verification this has been done through a "Proof of Service" form or other formal verification process.
   - Employer's First Report of Injury (5020) should be completed within five (5) calendar days of knowledge of injury.
   - The Employer's First Report and Employee's Claim Form should be sent to York Risk Services Group, Inc. immediately upon completion.

FREQUENTLY ASKED QUESTIONS (FAQ's)
(Continued)

D. Where does the employee receive medical treatment?

1. In the case of serious life-threatening injury or illness, the nearest emergency room medical facility.
2. In the case of an ambulatory, non-life-threatening injury or illness, the nearest employer designated occupational medical facility.
3. If there is a chance of causing more serious injury or illness due to staff moving the injured employee, an ambulance should be called and notified that this is a workers' compensation injury.

E. Can an employee use his/her own medical doctor for treatment of an injury or illness?

1. For preliminary treatment, only if the employee has signed a request prior to the injury/illness and that request is in the employee's personnel file.
2. Thirty (30) days after the initial injury/illness the employee may request a change of treating physicians through the claims examiner.

F. When can the employee return to work?

1. Following the receipt of treatment by the doctor, the doctor should provide the employee with a return-to-work slip, which will tell the supervisor if the employee can return to work and under what conditions.
2. If the return-to-work slip is unclear as to the conditions under which an employee can return, the supervisor should call the claims examiner for clarification. The employee should not be returned to work until clarification is received.

G. Does the employer have to take an employee back for limited duty?

The employer can review the conditions of return to work from the doctor. If the employer can't accommodate those conditions without further aggravating the injury/illness, the employer does not have to bring the employee back until work is available that would not aggravate the injury/illness. If a limited duty program is created, it must be offered equally to all workers' comp injured workers in the specific job classification.

FREQUENTLY ASKED QUESTIONS (FAQ's)
(Continued)

H. Who pays for any doctor bill, hospitalization charges, ambulance fees, and/or medication that result from the injury/illness?

1. If the injury/illness is accepted as a legitimate workers' comp claim, then the employer, through the claims administrator, pays these expenses for the employee.
2. If the claim is accepted and the employee receives a bill for the above services, the supervisor should obtain the bill and send it to the claims examiner for payment.

I. When does an employee begin to receive his workers' comp disability payments?

1. If an employee is off more than three calendar days due to a workers' comp injury/illness, he/she will begin receiving workers' compensation temporary disability payments. These payments may be supplemented with an employee's accrued sick leave and vacation to provide a full paycheck. The supplemental payments are not tax-free.
2. Police officers and firemen receive full pay, tax-free from the first day of disability for up to one year.
3. If an employee runs out of supplements, he/she will continue to receive the temporary disability payments as long as he/she is off work and eligible for the benefits.

J. Are workers' comp injuries always accepted as job related and benefits provided to the employee?

No. There are three notices that can be sent to an employee regarding their workers' comp claim. The first notice is that the claim is accepted. The second notice states that acceptance or denial is delayed for up to 90 days pending the receipt of more information to determine whether or not the claim is accepted. The third notice states that the claim is rejected as not being work related and no benefits will be provided. If the acceptance of a claim is delayed and later accepted, then all benefits due to the employee, from the date of injury, will be provided.

K. If I know that the employee is faking or was injured off the job, what can I do?

If you are aware of the possibility that this is not a work-related injury, contact the claims examiner and provide him/her with the information you have. An investigation will be conducted and the claim will be reviewed to see if it is a valid claim.

FREQUENTLY ASKED QUESTIONS (FAQ's)
(Continued)

L. If the employee is off work, what can I do to get him/her back?

Once a doctor takes an employee off work for a workers' comp injury/illness, it takes a doctor's statement to bring the employee back to full or limited duty. If you have knowledge that the employee is doing similar work while off, contact the claims examiner and he/she will investigate the matter, including talking to the doctor about returning the employee to duty.

M. Does the employee have the right to an attorney in workers' comp cases?

Yes. The benefits are very specific in the law; however, some employees want an attorney to represent them. Once a settlement is reached in the case, the attorney gets a certain percentage of the employee's settlement. If you know an employee has an attorney, you should not discuss the details of the case with the employee. You can discuss how the employee is feeling and when the doctor may allow them back to work and/or whether they have future medical appointments.

N. What can I do about follow-up treatment or evaluations for accepted workers' comp claims?

The employee has the right to any follow-up treatment or evaluation ordered by a physician. They will be paid mileage to and from the doctor's office. If the employee has returned to work and has treatment or an evaluation, you can request that he/she schedule the treatment at the beginning or ending of a shift to reduce disruption to the work site. The employee will not receive a temporary disability payment for treatment or a follow-up evaluation unless the treatment requires that the employee miss his/her entire normal work shift.

O. Why must an employee talk to a rehabilitation counselor if he/she is going to return to work?

For injuries prior to January 1, 2004, if an employee is off work more than 90 days, even if he/she will be returning to work, a rehabilitation counselor must be assigned to the case. The counselor must speak with the employee about the potential of rehabilitation. It does not mean that the employee can no longer work at his/her old job. It also does not mean the employee must be rehabilitated.

FREQUENTLY ASKED QUESTIONS (FAQ's)
(Continued)

P. When can I replace an employee if he/she cannot return to work because of the workers' comp injury?

1. Generally, once a doctor has declared the employee's condition to be permanent and stationary (P&S) and has defined the conditions of work which preclude the employee from returning to work, you can replace the employee. However, before taking any action, you should check with your personnel department and York Risk Services Group, Inc.

2. Under recent federal law established through the Americans with Disabilities Act (PL 101-336), an employer is required to try and make "reasonable accommodations" for an injured employee trying to return to work. Reasonable accommodation should be explored and documented before making a final decision to release/replace an employee.

Q. What are some of the benefits due an employee who is injured at work?

1. If the claim is accepted as legitimate, the following are some of the benefits:
   - ♦ The employee's injury/illness-related medical bills and transportation will be paid.
   - ♦ If the employee misses work, he/she will receive tax-free temporary disability payments until the employee returns to work, is retired, or the case is closed.
   - ♦ If the employee cannot return to his/her normal job, rehabilitation services will be offered which will either place him/her in another job or will provide training and replacement in another job. While in rehabilitation, the employee will receive vocational rehabilitation temporary disability (VRMA) payments.
   - ♦ The employee may be eligible for a cash payment for permanent disability if it is found that the employee has suffered some percentage of permanent disability due to the injury. The amount of the payment is determined by medical statements about the degree of permanent disability by a physician, and the use of a state mandated rating system.
   - ♦ If the employee dies due to a work-related injury, there are specific burial and death benefits provided to his/her dependents.

FREQUENTLY ASKED QUESTIONS (FAQ's)
(Continued)

R. What are the different types of workers' compensation injuries?

Specific Injuries:
Struck by object, slip & fall, cuts, back strain while lifting, etc.

Cumulative Trauma:
Condition caused by repetitive activities developing over time.
Example: Carpal Tunnel Syndrome

Aggravation Injuries:
A pre-existing condition worsened by some aspect of employment--prior injury and medical records crucial (apportionment). Examples: back, psyche, heart, etc.

REMEMBER:

Exacerbation is same injury.

Aggravation is a new injury.

S. What is a First Aid Injury?

Per Labor Code 9780(4)(f) "First Aid" is any one-time treatment and one follow-up visit (even if provided by a physician or healthcare professional) for the purpose of observation of minor scratches, cuts, burns, splinters etc. which do not ordinarily require medical care.

What First Aid <u>Does Not</u> Include:

1. ***Pesticide Poisoning:*** Any one time treatment administered for pesticide poisoning or suspected pesticide poisoning is not included in the definition of first aid. Therefore, all pesticide poisoning claims must be reported irrespective of the level or number of treatments.

2. ***Hazardous Substances:*** First aid does not include any one-time treatment by a physician for any serious exposure to a hazardous substance as a result of a specific incident or over time, in a degree or amount sufficient to create a substantial probability that death or serious physical harm in the future could result from the exposure.

3. ***Loss of Consciousness, Restriction from Work or Motion or Transfer to Another Job:*** First aid does not include any injuries resulting from loss of consciousness, restriction from work or motion or transfer to another job.

First aid claims **<u>do not</u>** have a minimum or maximum dollar amount threshold.

FREQUENTLY ASKED QUESTIONS (FAQ's)
(Continued)

T. Why does the claims examiner need the employee's payroll log or wage statement?

At the time of the injury, the claims administrator must have earnings of the employee's "gross" wages for one year BEFORE the injury. This report can usually be generated from the payroll department and faxed when the new loss is reported. This information is required by the WCAB when claimant is not earning max-disability benefits. A new wage statement will also be needed if an employee is entitled to disability benefits two years after the date of injury, due to possible increases.

SCORE MEMBER PARTICIPATION FY 18/19

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
Town Of Fort Jones
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Alliant Insurance Services
100 Pine Street, 11th Floor
San Francisco, CA 94111

SCORE
Small Cities Organized Risk Effort
A Joint Powers Authority

Policy Period

July 1, 2018 – June 30, 2019

Services Performed By:

York Risk Services
PO Box 619079
Roseville, CA 95678

Services Performed For:

Small Cities Organized Risk Effort
2180 Harvard Street STE 460
Sacramento, CA 95815

APIP Property Claims Contacts

Alliant Insurance Services, Inc. ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466***
Robert A. Frey — RPA, Senior Vice President, Regional Claims Director ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1445 Email: rfrey@alliant.com***
Diana Walizada — AIC, CPIW, RPA, AINS Vice President, Claims Unit Manager ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1453 Email: dwalizada@alliant.com***
Sandra Doig — McLaren's Global Claims Services ***1301 Dove Street, Suite 200, Newport Beach, CA 92660*** ***Phone: 949-757-1413 Email: sandra.doig@mclarens.com***
Marcus Beverly — First Vice President, CPCU, AIC, ARM-P ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
Michelle Minnick — Assistant Account Manager ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***

Client Responsibilities for Reporting Claims

During regular business hours (between 8:30 AM and 5:00 PM PST) First Notice of Claim should be reported to Alliant Insurance Services via telephone, fax, mail or e-mail to our San Francisco Office. Please include the Insured /JPA name along with the following information when reporting claims:

- Time, date and specific location of property damaged
- A description of the incident that caused the damage (such as fire, theft or water damage)
- Estimated amount of loss in dollars
- Contact person for claim including name, title, voice & fax numbers
- Complete and return the Property Loss Notice for processing.
- Mortgagee or Loss Payee name, address, and account number

LOSS NOTIFICATION REQUIREMENT

ALLIANT PROPERTY INSURANCE PROGRAM (APIP)

Claim notifications need to be sent to Robert Frey, Diana Walizada and Sandra Doig. In the event this is a *Cyber* loss please include item III contact, for a *Pollution* loss please include item IV contact in addition to Alliant Insurance Services contacts.

I. During regular business hours (between 8:30 AM and 5:00 PM PST), First Notice of Claim should be reported to Alliant Insurance Services via telephone, fax, mail or e-mail to our San Francisco Office:

Robert A. Frey, RPA
Senior Vice President, Regional Claims Director
Voice: (415) 403-1445 Cell: (415) 518-8490
Email: rfrey@alliant.com

Diana L. Walizada, AIC, CPIW, RPA, AINS
Vice President, Claims Unit Manager
Voice:(415)403-1453
Email: dwalizada@alliant.com

Address: Alliant Insurance Services, Inc.
100 Pine St, 11th Floor
San Francisco CA 94111
Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466

II. Please be sure to include APIP's Claim Administrator as a CC on all Claims correspondence:

Sandra Doig
McLaren's Global Claims Services
Address: 1301 Dove St., Suite 200
Newport Beach, CA 92660
Voice: (949) 757-1413 Fax: (949) 757-1692
Email: sandra.doig@mclarens.com

III. Cyber Liability Carrier Beazley NY needs to also be provided with Notice of Claim immediately (if purchased):

Beth Diamond
Beazley Group
Address: 1270 Avenue of the America's, Suite 1200
New York, NY 10020
Fax: (546) 378-4039
Email: tmbclaims@beazley.com

Elaine G. Tizon, CISR
Assistant Vice President, Claims Advocate
Address: 100 Pine Street, 11th Floor
San Francisco, CA 94111-5101
Voice: (415) 403-1458 Fax: (415) 403-1466
Email: elaine.tizon@alliant.com

IV. Pollution Liability Carrier ACE Environmental, Risk Claims Manager (if purchased):

ACE USA Claims
Address: PO Box 5103
Scranton, PA 18505-0510
Environmental Emergency: (888) 310-9553
Fax: (800) 951-4119
Email: CasualtyRiskEnvironmentalFirstNotice@chubb.com

Akbar Sharif
Claims Advocate
Address: 1301 Dove St. Ste. 200
Newport Beach, CA 92646
Voice: (949) 260-5088 Fax: (415) 403-1466
Email: asharif@alliant.com

Please include the Insured /JPA name along with the following information when reporting claims:

- Time, date and specific location of property damaged
- A description of the incident that caused the damage (such as fire, theft or water damage)
- Estimated amount of loss in dollars
- Contact person for claim including name, title, voice & fax numbers
- Complete and return the Property Loss Notice for processing.
- Mortgagee or Loss Payee name, address, and account number

IN THE EVENT OF A

PROPERTY LOSS:

1) Follow your organization procedures for reporting and responding to an incident

2) Alert local emergency authorities, as appropriate

3) Report the incident to Alliant Insurance Services *immediately at:*

877-725-7695

All property losses must be reported as soon as practicable upon knowledge within the risk management or finance division of the insured that a loss has occurred.

Be prepared to give basic information about the location and nature of the incident, as well as steps which have been taken in response to the incident.

4) Report the incident to McLarens Global Claims Services AND your Alliant representative

PROPERTY FIRST NOTICE OF LOSS FORM

SEND TO: Alliant Insurance Services, Inc.
BY MAIL: 100 Pine Street, 11th Floor, San Francisco, CA 94111
BY FAX: (415) 403-1466
BY EMAIL: rfrey@alliant.com AND dwalizada@alliant.com
Carbon Copy APIP Claims Administrator: sandra.doig@mclarens.com and your Alliant representative

Today's Date: _____

Type of Claim: (check all that apply)

☐ **Real Property** ☐ **Vehicles**

☐ **Personal Property** ☐ **Other**

Insured's Name & Contact Information

Insured's Name:_____ Point of Contact:_____

Address:_____

Phone #:_____

Broker/Agent's Name & Contact Information

Company Name: Alliant Insurance Services - Claims Point of Contact: Robert A. Frey & Diana L. Walizada

Address: 100 Pine Street, 11th Floor, San Francisco, CA 94111

Phone #: 1-877-725-7695 Fax #: 415-403-1466

Policy Information

Policy Number:_____Policy Period: _____

Limits of Liability: _____per_____agg Self-Insured Retention/Deductible: _____

Loss Information

Date of Incident/Claim: _____ Location:_____

Description of Loss:

_____

_____

Please list all attached or enclosed documentation: ☐(check if none provided) _____

_____

Name of Person Completing This Form: _____

Signature:_____

Per the PEPIP USA Form Master Policy Wording, Section IV General Conditions;

J. NOTICE OF LOSS

In the event of loss or damage insured against under this Policy, the Insured shall give notice thereof to ALLIANT INSURANCE SERVICES, INC., 100 Pine Street, 11th Floor, San Francisco, CA 94111-1073. TEL NO. (877) 725-7695, FAX NO. (415) 403-1466 of such loss. Such notice is to be made as soon as practicable upon knowledge within the risk management or finance division of the insured that a loss has occurred.

SCORE MEMBER PARTICIPATION FY 18/19

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
Town Of Fort Jones
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Alliant Insurance Services
100 Pine Street, 11th Floor
San Francisco, CA 94111

SCORE
Small Cities Organized Risk Effort
A Joint Powers Authority

Policy Period

July 1, 2018 – June 30, 2019

Services Performed By:

Alliant Insurance Services
100 Pine Street, 11th Floor
San Francisco, CA 94111

Services Performed For:

Small Cities Organized Risk Effort
2180 Harvard Street STE 460
Sacramento, CA 95815

APIP Cyber Claims Contacts

Beth Diamond — Beazley Group ***1270 Avenue of the America's, Suite 1200, New York, NY 10020*** ***Fax: 546-378-4039 Email: tmbclaims@beazley.com***
Elaine Tizon — CISR, Assistant Vice President, Claims Advocate ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1445 Email: elaine.tizon@alliant.com***
Alliant Insurance Services, Inc. ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466***
Robert A. Frey — RPA, Senior Vice President, Regional Claims Director ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1445 Email: rfrey@alliant.com***
Diana Walizada — AIC, CPIW, RPA, AINS Vice President, Claims Unit Manager ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1453 Email: dwalizada@alliant.com***
Sandra Doig — McLaren's Global Claims Services ***1301 Dove Street, Suite 200, Newport Beach, CA 92660*** ***Phone: 949-757-1413 Email: sandra.doig@mclarens.com***

Client Responsibilities for Reporting Claims

During regular business hours (between 8:30 AM and 5:00 PM PST) First Notice of Claim should be reported to Alliant Insurance Services via telephone, fax, mail or e-mail to our San Francisco Office. Cyber Liability Carrier Beazley NY needs to also be provided with Notice of Claim immediately. Please include the Insured /JPA name along with the following:

- Time, date and specific location of property damaged
- A description of the incident that caused the damage (such as fire, theft or water damage)
- Estimated amount of loss in dollars
- Contact person for claim including name, title, voice & fax numbers
- Complete and return the Property Loss Notice for processing.
- Mortgagee or Loss Payee name, address, and account number

LOSS NOTIFICATION REQUIREMENT

ALLIANT PROPERTY INSURANCE PROGRAM (APIP)

Claim notifications need to be sent to Robert Frey, Diana Walizada and Sandra Doig. In the event this is a *Cyber* loss please include item III contact, for a *Pollution* loss please include item IV contact in addition to Alliant Insurance Services contacts.

I. During regular business hours (between 8:30 AM and 5:00 PM PST), First Notice of Claim should be reported to Alliant Insurance Services via telephone, fax, mail or e-mail to our San Francisco Office:

Robert A. Frey, RPA
Senior Vice President, Regional Claims Director
Voice: (415) 403-1445 Cell: (415) 518-8490
Email: rfrey@alliant.com

Diana L. Walizada, AIC, CPIW, RPA, AINS
Vice President, Claims Unit Manager
Voice:(415)403-1453
Email: dwalizada@alliant.com

Address: Alliant Insurance Services, Inc.
100 Pine St, 11th Floor
San Francisco CA 94111
Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466

II. Please be sure to include APIP's Claim Administrator as a CC on all Claims correspondence:

Sandra Doig
McLaren's Global Claims Services
Address: 1301 Dove St., Suite 200
Newport Beach, CA 92660
Voice: (949) 757-1413 Fax: (949) 757-1692
Email: sandra.doig@mclarens.com

III. Cyber Liability Carrier Beazley NY needs to also be provided with Notice of Claim immediately (if purchased):

Beth Diamond
Beazley Group
Address: 1270 Avenue of the America's, Suite 1200
New York, NY 10020
Fax: (546) 378-4039
Email: tmbclaims@beazley.com

Elaine G. Tizon, CISR
Assistant Vice President, Claims Advocate
Address: 100 Pine Street, 11th Floor
San Francisco, CA 94111-5101
Voice: (415) 403-1458 Fax: (415) 403-1466
Email: elaine.tizon@alliant.com

IV. Pollution Liability Carrier ACE Environmental, Risk Claims Manager (if purchased):

ACE USA Claims
Address: PO Box 5103
Scranton, PA 18505-0510
Environmental Emergency: (888) 310-9553
Fax: (800) 951-4119
Email: CasualtyRiskEnvironmentalFirstNotice@chubb.com

Akbar Sharif
Claims Advocate
Address: 1301 Dove St. Ste. 200
Newport Beach, CA 92646
Voice: (949) 260-5088 Fax: (415) 403-1466
Email: asharif@alliant.com

Please include the Insured /JPA name along with the following information when reporting claims:

- Time, date and specific location of property damaged
- A description of the incident that caused the damage (such as fire, theft or water damage)
- Estimated amount of loss in dollars
- Contact person for claim including name, title, voice & fax numbers
- Complete and return the Property Loss Notice for processing.
- Mortgagee or Loss Payee name, address, and account number

IN THE EVENT OF A

CYBER LOSS:

1) *Follow your organizations procedures for reporting and responding to an incident*

2) *Alert authorities, as appropriate*

3) *Report the incident to* Beazley Group *immediately at:*

tmbclaims@beazley.com

All Cyber losses must be reported as soon as practicable upon knowledge by the insured that a loss has occurred.

Be prepared to give basic information about the location and nature of the incident, as well as steps which have been taken in response to the incident.

4) *Report the incident to Alliant Claims Department and your Alliant representative*

SPECIAL NOTE REGARDING PRIVACY NOTIFICATION COSTS:

The policy provides a $500,000 Aggregate Limit for Privacy Notification Costs. If you utilize a Beazley vendor, the limit is increased to $1,000,000.

Please contact Beazley for a list of approved vendors.

CYBER FIRST NOTICE OF LOSS FORM

SEND TO: Beazley Group

BY MAIL: 1270 Avenue of the America's, Suite 1200, New York, NY 10020

BY FAX: (546) 378-4039

BY EMAIL: tmbclaims@beazley.com

CC Alliant Claims Department:
elaine.tizon@alliant.com , **and your Alliant representative**

Today's Date: _____

Insured's Name & Contact Information

Insured's Name:_____ **Point of Contact:**_____

Address:_____

Phone #:_____

Broker/Agent's Name & Contact Information

Company Name: Alliant Insurance Services – Claims **Point of Contact:** Elaine Tizon

Address: 100 Pine Street, 11th Floor, San Francisco, CA 94111

Phone #: 877-725-7695 Fax #:415-403-1466

Policy Information

Policy Number:_____ **Policy Period:**_____

Limits of Liability:_____**per**_____**agg Self-Insured Retention/Deductible**_____

Loss Information

Date of Incident/Claim:_____ **Location:**_____

Description of Loss:_____

_____

Please list all attached or enclosed documentation: ☐**(check if none provided)**_____

_____

Name of Person Completing This Form:_____

Signature:_____

A. NOTICE OF CLAIM, LOSS OR CIRCUMSTANCE THAT MIGHT LEAD TO A CLAIM

1. If any **Claim** is made against the **Insured**, the **Insured** shall, as soon as practicable upon knowledge by the **Insured**, forward to the Underwriters through persons named in Item 9.A. of the Declarations written notice of such **Claim** in the form of a telecopy, or express or certified mail together with every demand, notice, summons or other process received by the **Insured** or the **Insured's** representative; provided that with regard to coverage provided under Insuring Agreements I.A. and I.C., all **Claims** made against any **Insured** must be reported no later than the end of the **Policy Period**, in accordance with the requirements of the **Optional Extension Period** (if applicable), or within thirty (30) days after the expiration date of the **Policy Period** in the case of **Claims** first made against the Insured during the last thirty (30) days of the **Policy Period**.

2. With respect to Insuring Agreement I.B. for a legal obligation to comply with a **Breach Notice Law** because of an incident (or reasonably suspected incident) described in Insuring Clause I.A.1 or I.A.2, such incident or reasonably suspected incident must be reported as soon as practicable during the **Policy Period** after discovery by the Insured. For such incidents or suspected incidents discovered by the **Insured** within 60 days prior to expiration of the Policy, such incident shall be reported as soon as practicable, but in no event later than 60 days after the end the **Policy Period**, provided; if this Policy is renewed by Underwriters and covered **Privacy Notification Costs** are incurred because of such incident or suspected incident reported during the 60 day post **Policy Period** reporting period, then any subsequent **Claim** arising out of such incident or suspected incident is deemed to have been made during the **Policy Period**.

3. With respect to Insuring Agreements I.A. and I.C., if during the **Policy Period**, the **Insured** first becomes aware of any circumstance that could reasonably be the basis for a **Claim** it may give written notice to Underwriters in the form of a telecopy, or express or certified mail through persons named in Item 9.A. of the Declarations as soon as practicable during the **Policy Period** of:

   a. the specific details of the act, error, omission, or **Security Breach** that could reasonably be the basis for a **Claim**;
   b. the injury or damage which may result or has resulted from the circumstance; and
   c. the facts by which the **Insured** first became aware of the act, error, omission or **Security Breach**

   Any subsequent **Claim** made against the **Insured** arising out of such circumstance which is the subject of the written notice will be deemed to have been made at the time written notice complying with the above requirements was first given to the Underwriters.

4. A **Claim** or legal obligation under section X.A.1 or X.A.2 above shall be considered to be reported to the Underwriters when written notice is first received by Underwriters in the form of a telecopy, or express or certified mail or email through persons named in Item 9.A. of the Declarations of the **Claim** or legal obligation, or of an act, error, or omission, which could reasonably be expected to give rise to a **Claim** if provided in compliance with sub-paragraph X.A.3. above.

(Cyber)

SCORE MEMBER PARTICIPATION FY 18/19

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
Town Of Fort Jones
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

ACE Environmental Risk

PO Box 5103
Scranton, PA 18505-0510

SCORE
Small Cities Organized Risk Effort
A Joint Powers Authority

Policy Period

July 1, 2018 –
June 30, 2019

Services Performed By:

ACE Environmental Risk
PO Box 5103
Scranton, PA 18505-0510

Services Performed For:

Small Cities Organized Risk Effort
2180 Harvard Street STE 460
Sacramento, CA 95815

APIP Pollution Claims Contacts

i	***ACE USA Claims*** ***PO BOX 5103, Scranton, PA 18505-0510*** ***Environmental Emergency: 888-310-9553*** ***Fax: 546-378-4039 Email: CasualtyRiskEnvironmentalFirstNotice@chubb.com***
i	***Akbar Sharif — Claims Advocate*** ***1301 Dove Street, Suite 200, Newport Beach, CA 92660*** ***Phone: 949-260-5088 Email: asharif@alliant.com***
i	***Alliant Insurance Services, Inc.*** ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466***
i	***Robert A. Frey — RPA, Senior Vice President, Regional Claims Director*** ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1445 Email: rfrey@alliant.com***
i	***Diana Walizada — AIC, CPIW, RPA, AINS Vice President, Claims Unit Manager*** ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1453 Email: dwalizada@alliant.com***
i	***Sandra Doig — McLaren's Global Claims Services*** ***1301 Dove Street, Suite 200, Newport Beach, CA 92660*** ***Phone: 949-757-1413 Email: sandra.doig@mclarens.com***

Client Responsibilities for Reporting Claims

i

During regular business hours (between 8:30 AM and 5:00 PM PST) First Notice of Claim should be reported to Alliant Insurance Services via telephone, fax, mail or e-mail to our San Francisco Office. Pollution Liability Carrier ACE Environmental needs to also be provided with Notice of Claim immediately. Please include the Insured /JPA name along with the following:

- Time, date and specific location of property damaged
- A description of the incident that caused the damage (such as fire, theft or water damage)
- Estimated amount of loss in dollars
- Contact person for claim including name, title, voice & fax numbers
- Complete and return the Property Loss Notice for processing.
- Mortgagee or Loss Payee name, address, and account number

LOSS NOTIFICATION REQUIREMENT

ALLIANT PROPERTY INSURANCE PROGRAM (APIP)

Claim notifications need to be sent to Robert Frey, Diana Walizada and Sandra Doig. In the event this is a *Cyber* loss please include item III contact, for a *Pollution* loss please include item IV contact in addition to Alliant Insurance Services contacts.

I. During regular business hours (between 8:30 AM and 5:00 PM PST), First Notice of Claim should be reported to Alliant Insurance Services via telephone, fax, mail or e-mail to our San Francisco Office:

Robert A. Frey, RPA
Senior Vice President, Regional Claims Director
Voice: (415) 403-1445 Cell: (415) 518-8490
Email: rfrey@alliant.com

Diana L. Walizada, AIC, CPIW, RPA, AINS
Vice President, Claims Unit Manager
Voice:(415)403-1453
Email: dwalizada@alliant.com

Address: Alliant Insurance Services, Inc.
100 Pine St, 11th Floor
San Francisco CA 94111
Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466

II. Please be sure to include APIP's Claim Administrator as a CC on all Claims correspondence:

Sandra Doig
McLaren's Global Claims Services
Address: 1301 Dove St., Suite 200
Newport Beach, CA 92660
Voice: (949) 757-1413 Fax: (949) 757-1692
Email: sandra.doig@mclarens.com

III. Cyber Liability Carrier Beazley NY needs to also be provided with Notice of Claim immediately (if purchased):

Beth Diamond
Beazley Group
Address: 1270 Avenue of the America's, Suite 1200
New York, NY 10020
Fax: (546) 378-4039
Email: tmbclaims@beazley.com

Elaine G. Tizon, CISR
Assistant Vice President, Claims Advocate
Address: 100 Pine Street, 11th Floor
San Francisco, CA 94111-5101
Voice: (415) 403-1458 Fax: (415) 403-1466
Email: elaine.tizon@alliant.com

IV. Pollution Liability Carrier ACE Environmental, Risk Claims Manager (if purchased):

ACE USA Claims
Address: PO Box 5103
Scranton, PA 18505-0510
Environmental Emergency: (888) 310-9553
Fax: (800) 951-4119
Email: CasualtyRiskEnvironmentalFirstNotice@chubb.com

Akbar Sharif
Claims Advocate
Address: 1301 Dove St. Ste. 200
Newport Beach, CA 92646
Voice: (949) 260-5088 Fax: (415) 403-1466
Email: asharif@alliant.com

Please include the Insured /JPA name along with the following information when reporting claims:

- Time, date and specific location of property damaged
- A description of the incident that caused the damage (such as fire, theft or water damage)
- Estimated amount of loss in dollars
- Contact person for claim including name, title, voice & fax numbers
- Complete and return the Property Loss Notice for processing.
- Mortgagee or Loss Payee name, address, and account number

CHUBB®

Chubb Environmental

IN THE EVENT OF AN

ENVIRONMENTAL EMERGENCY:

1) ***Follow your organization procedures for reporting and responding to an incident***

2) ***Alert local emergency authorities, as appropriate***

3) ***Report the incident to*** **ACE Environmental Risk** ***immediately at:***

888-310-9553 or use ACE Alert App

4] Report the incident to Alliant

Akbar Sharif
Claims Advocate
949-260-5088
415-403-1466 – fax
asharif@alliant.com

Be prepared to give basic information about the location and nature of the incident, as well as steps which have been taken in response to the incident. You will be contacted by a trained representative of ACE to discuss further response steps as soon as possible.

DO follow your organization's detailed response plan
DO contact your management as well as appropriate authorities
DO ensure anyone who could come in contact with a spill or release is kept away

DO NOT ignore a potential spill or leak
DO NOT attempt to respond beyond your level of training or certification

CHUBB ENVIRONMENTAL FIRST NOTICE OF LOSS FORM

SEND TO: Chubb Environmental Claims Manager
BY MAIL: ACE USA Claims, P.O. Box 5103, Scranton, PA 18505-0510
BY FAX: (800) 951-4119
BY EMAIL: CasualtyRiskEnvironmentalFirstNotice@chubb.com
CC Alliant Insurance: asharif@alliant.com **and your Alliant Representative**

Today's Date: _____

Notice of: (check all that apply)

☐ **Pollution Incident** ☐ **Potential Claim** ☐ **Other** _____

☐ **Third-Party Claim** ☐ **Litigation Initiated**

Insured's Name & Contact Information

Company Name: _____ **Point of Contact:** _____

Address: _____

Phone #: _____

Broker/Agent's Name & Contact Information

Company Name: Alliant Insurance Services - Claims **Point of Contact:** Akbar Sharif

Address: 1301 Dove St. Ste. 200 Newport Beach, CA 92660

Phone #: 1-949-260-5088

Policy Information

Policy Number: _____ **Policy Period:** _____

Limits of Liability: _____ **per** _____ **agg** **Self-Insured Retention/Deductible** _____

Loss Information

Date of Incident/Claim: _____ **Location:** _____

Claimant Name/Address: _____

Description of Loss: _____

_____

Please list all attached or enclosed documentation: ☐**(check if none provided)** _____

_____

Name of Person Completing This Form: _____ **Signature:** _____

VII. REPORTING AND COOPERATION

A. The "insured" must see to it that the Insurer receives written notice of any "claim" or "pollution condition", as soon as practicable, at the address identified in Item 7.a. of the Declarations to this Policy. Notice should include reasonably detailed information as to:

1. The identity of the "insured", including contact information for an appropriate person to contact regarding the handling of the "claim" or "pollution condition";
2. The identity of the "covered location" or "covered operations";
3. The nature of the "claim" or "pollution condition"; and
4. Any steps undertaken by the "insured" to respond to the "claim" or "pollution condition". In the event of a "pollution condition", the "insured" **must also take all reasonable measures to provide immediate verbal notice to the Insurer.**

B. The "insured" must:

1. As soon as practicable, send the Insurer copies of any demands, notices, summonses or legal papers received in connection with any "claim";
2. Authorize the Insurer to obtain records and other information;
3. Cooperate with the Insurer in the investigation, settlement or defense of the "claim";
4. Assist the Insurer, upon the Insurer's request, in the enforcement of any right against any person or organization which may be liable to the "insured" because of "bodily injury", "property damage", "remediation costs" or "legal defense expense" to which this Policy may apply; and
5. Provide the Insurer with such information and cooperation as it may reasonably require.

C. No "insured" shall make or authorize an admission of liability or attempt to settle or otherwise dispose of any "claim" without the written consent of the Insurer. **Nor shall any "insured" retain any consultants or incur any "remediation costs" without the prior express written consent of the Insurer, except in the event of an "emergency response". (Emergency Response coverage is limited to the first 7 days)**

D. Upon the discovery of a "pollution condition", the "insured" shall make every attempt to mitigate any loss and comply with applicable "environmental law". The Insurer shall have the right, but not the duty, to mitigate such "pollution conditions" if, in the sole judgment of the Insurer, the "insured" fails to take reasonable steps to do so. In that event, any "remediation costs" incurred by the Insurer shall be deemed incurred by the "insured", and shall be subject to the "self-insured retention" and Limits of Liability identified in the Declarations to this Policy.

APIP Pollution: Claim Reporting Fact Sheet

This page outlines the steps that should be taken BY YOUR ORGANIZATION, at the time of an environmental incident, to assure that the Pollution coverage offered with ACE through APIP is not jeopardized. We ask that you review this document and provide copies to all appropriate colleagues in advance of a possible incident.

Coverage under Pollution policies is dependent on specific compliance with claims and loss reporting; *especially* in the case of "Emergency Response" expenses that you may incur to address a pollution loss. For these "Emergency Response" expenses there is a strict seven (7) day window, following discovery of a "Pollution Condition" by the "Insured", after which reasonable expenses will not be reimbursed unless the carrier has given prior consent. It is **extremely important** pollution exposures be reported **immediately;** and clearly no later than seven (7) days.

Although we ask that you fully review your policy and all its' Terms and Conditions, we have highlighted some key sections of the ACE policy which address the ***Emergency Response*** issue and the reporting provisions:

> **III. DEFENSE AND SETTLEMENT** C. The "insured" shall have the right and duty to retain a qualified environmental consultant to perform any investigation and/or remediation of any "pollution condition" covered pursuant to this Policy. The "insured" must receive the written consent of the Insurer prior to the selection and retention of such consultant, except in the event of an "emergency response". Any costs incurred prior to such consent shall not be covered pursuant to this Policy, or credited against the "self-insured retention", except in the event of an "emergency response".
>
> **V. DEFINITIONS**
>
> **F. "Emergency response"** means actions taken and reasonable "remediation costs" 7 days following the discovery of a "pollution condition" by an "insured" in order to abate or respond to an imminent and substantial threat to human health or the environment arising out of such "pollution condition".
>
> **T. "Pollution condition"** means: **2.** The discharge, dispersal, release, escape, migration, or seepage of any solid, liquid, gaseous or thermal irritant, contaminant, or pollutant, including smoke, soot, vapors, fumes, acids, alkalis, chemicals, hazardous substances, hazardous materials, or waste materials, on, in, into, or upon land and structures thereupon, the atmosphere, surface water, or groundwater.
>
> **V. "Remediation costs"** means reasonable expenses incurred to investigate, quantify, monitor, mitigate, abate, remove, dispose, treat, neutralize, or immobilize "pollution conditions" to the extent required by "environmental law".
>
> **VII. REPORTING AND COOPERATION**
>
> **A.** The "insured" must see to it that the Insurer receives written notice of any "claim" or "pollution condition", as soon as practicable, at the address identified in Item **7.a.** of the Declarations to this Policy. Notice should include reasonably detailed information as to: **1.** The identity of the "insured", including contact information for an appropriate person to contact regarding the handling of the "claim" or "pollution condition";
>
> **B.** The "insured" must: **1.** As soon as practicable, send the Insurer copies of any demands, notices, summonses or legal papers received in connection with any "claim";
>
> **C.** No "insured" shall make or authorize an admission of liability or attempt to settle or otherwise dispose of any "claim" without the written consent of the Insurer. Nor shall any "insured" retain any consultants or incur any "remediation costs" without the prior express written consent of the Insurer, except in the event of an "emergency response". (Emergency Response coverage is limited to the first 7 days)
>
> **D.** Upon the discovery of a "pollution condition", the "insured" shall make every attempt to mitigate any loss and comply with applicable "environmental law". The Insurer shall have the right, but not the duty, to mitigate such "pollution conditions" if, in the sole judgment of the Insurer, the "insured" fails to take reasonable steps to do so. In that event, any "remediation costs" incurred by the Insurer shall be deemed incurred by the "insured", and shall be subject to the "self-insured retention" and Limits of Liability identified in the Declarations to this Policy.

The bottom line is if there is a Pollution event, please contact us **immediately** so that we can report the Incident and properly protect coverage for these unexpected events; please refer to the Claims Reporting form for proper contact information

SCORE MEMBER PARTICIPATION FY 18/19

City of Biggs
City Of Colfax
City Of Dunsmuir
Town Of Fort Jones
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Chubb Enviornmental
P.O. Box 5103
Scranton, PA 18505-0510

SCORE
Small Cities Organized Risk Effort
A Joint Powers Authority

Policy Period
July 1, 2018 –
June 30, 2019

Services Performed By:
Chubb Environmental
P.O. Box 5103
Scranton, PA 18505-0510

Services Performed For:
Small Cities Organized Risk Effort
2180 Harvard Street STE 460
Sacramento, CA 95815

CSAC EIA Pollution Claims Contacts

i	***Chubb Environmental Claims Manager – Chubb Claims*** ***P.O. Box 5103, Scranton, PA 18505-0510*** ***Phone: 800-310-9553 Fax: 800-951-4119*** ***Email: CasualtyRiskEnviornmentalFirstNotice@chubb.com***
i	***Akbar Sharif — Claims Advocate*** ***1301 Dove Street, Suite 200, Newport Beach, CA 92660*** ***Phone: 949-260-5088 Email: asharif@alliant.com***
i	***Alliant Insurance Services, Inc.*** ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Toll Free Voice: (877) 725-7695 Fax: (415) 403-1466***
i	***Robert A. Frey — RPA, Senior Vice President, Regional Claims Director*** ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1445 Email: rfrey@alliant.com***
i	***Diana Walizada — AIC, CPIW, RPA, AINS Vice President, Claims Unit Manager*** ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1453 Email: dwalizada@alliant.com***
i	***Sandra Doig — McLaren's Global Claims Services*** ***1301 Dove Street, Suite 200, Newport Beach, CA 92660*** ***Phone: 949-757-1413 Email: sandra.doig@mclarens.com***

Client Responsibilities for Reporting Claims

i

- Follow your entity's procedures for reporting and responding to an incident
- Alert local emergency authorities, as appropriate
- Report the incident to your Alliant Representative (see list above)
- Report the incident to Tokio Marine Specialty immediately at 1-800-765-9749
- Spills or releases involving Hazardous Materials or Petroleum Products require an immediate phone call to Tokio Marine Specialty: 1-800-765-9749— 24 hours a day, 365 days a year.

All Pollution incidents must be reported immediately upon discovery.

CHUBB®

Chubb Environmental

IN THE EVENT OF AN

ENVIRONMENTAL EMERGENCY:

1) *Follow your company procedures for reporting and responding to an incident*

2) *Alert local emergency authorities, as appropriate*

3) *Report the incident to* Chubb Environmental *through the Environmental Incident Alert system by one of the following methods:*

Phone: 888-310-9553

Website: www.chubbeia.net

Mobile Incident Reporting:

Available on the App Store

ANDROID APP ON Google play

Be prepared to give basic information about the location and nature of the incident, as well as steps which have been taken in response to the incident. You will be contacted by a trained representative of Chubb to discuss further response steps as soon as possible.

DO follow your company's detailed response plan
DO contact your management as well as appropriate authorities
DO ensure anyone who could come in contact with a spill or release is kept away

DO NOT ignore a potential spill or leak
DO NOT attempt to respond beyond your level of training or certification

CHUBB® CHUBB ENVIRONMENTAL FIRST NOTICE OF LOSS FORM

SEND TO: Chubb Environmental Claims Manager

BY MAIL: Chubb Claims, P.O. Box 5103, Scranton, PA 18505-0510

BY FAX: (800) 951-4119

BY EMAIL: CasualtyRiskEnvironmentalFirstNotice@chubb.com

Today's Date: _____

Notice of: (check all that apply)

☐ **Pollution Incident** ☐ **Potential Claim** ☐ **Other** _____

☐ **Third-Party Claim** ☐ **Litigation Initiated**

Insured's Name & Contact Information

Company Name:_____ **Point of Contact:**_____

Address:_____

Phone #:_____

Broker/Agent's Name & Contact Information

Company Name:_____**Point of Contact:**_____

Address:_____

Phone #:_____

Policy Information

Policy Number:_____ **Policy Period:**_____

Limits of Liability:_____**per**_____**agg** **Self-Insured Retention/Deductible**_____

Loss Information

Date of Incident/Claim:_____ **Location:**_____

Claimant Name/Address:_____

Description of Loss:_____

_____

_____

Please list all attached or enclosed documentation: ☐**(check if none provided)**_____

_____

_____

Name of Person Completing This Form:_____**Signature:**_____

SCORE MEMBER PARTICIPATION FY 18/19

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Rio Dell
City Of Shasta Lake
City Of Weed
City Of Yreka

AIG

Financial Lines Claims
PO Box 25947
Shawnee Mission, KS 66225

SCORE
Small Cities Organized Risk Effort
A Joint Powers Authority

Policy Period

July 1, 2018 – June 30, 2019

Services Performed By:

AIG-Financial Lines Claims
PO Box 25947
Shawnee Mission, KS 66225

Services Performed For:

Small Cities Organized Risk Effort
2180 Harvard Street STE 460
Sacramento, CA 95815

ALLIANT CRIME (ACIP) CLAIMS CONTACTS

i	***AIG — Financial Lines Claims*** ***PO Box 25947, Shawnee Mission, KS 66225*** ***Phone: 888-602-5246 Fax: 866-227-1750 Email: c-claim@aig.com***
i	***Robert A. Frey — RPA, Senior Vice President, Regional Claims Director*** ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1445 Email: rfrey@alliant.com***
i	***Diana Walizada — AIC, CPIW, RPA, AINS Vice President, Claims Unit Manager*** ***100 Pine Street, 11th Floor, San Francisco, CA 94111-5101*** ***Phone: 415-403-1453 Email: dwalizada@alliant.com***
i	***Sandra Doig — McLaren's Global Claims Services*** ***1301 Dove Street, Suite 200, Newport Beach, CA 92660*** ***Phone: 949-757-1413 Email: sandra.doig@mclarens.com***

CLIENT RESPONSIBILITIES FOR REPORTING CLAIMS

i

- Claims can be reported to AIG via regular mail to:
  AIG, Financial lines Claims
  PO Box 25947
  Shawnee Mission, KS 66225

- Claims may also be reported by email to: ***c-claim@aig.com***
  *NOTE: Your email must reference the policy number for this policy.

- Please be sure to forward a copy of the notice to:
  Alliant Insurance Services, Inc.
  ATTN: Robert Frey
  100 Pine Street, 11th Floor
  San Francisco, CA 94111
  Phone: 415-403-1400
  Fax: 415-403-1466

SCORE MEMBER PARTICIPATION FY 18/19

City of Biggs
City Of Colfax
City Of Live Oak
Town Of Loomis
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

ERMA

Employment Practice Liability Claims
1750 Creekside Oaks Drive STE 200
Sacramento, CA 95833

SCORE
Small Cities Organized Risk Effort
A Joint Powers Authority

Policy Period

July 1, 2018 –
June 30, 2019

Services Performed By:

ERMA EPL Claims
1750 Creekside Oaks Dre
STE 200
Sacramento, CA 95833

Services Performed For:

Small Cities Organized Risk
Effort
2180 Harvard Street STE 460
Sacramento, CA 95815

ERMA Employment Practice Liability Claims Contacts

i	***Lance Gerber — Legal Analyst*** ***Phone: 888-602-5246 Fax: 866-227-1750 Email: info@ermajpa.org***
i	***Cameron Dewey — Unit Manager, AIC, PCLA, LPCS*** ***Phone: 530-768-7385 Email: Cameron.dewey@yorkrsg.com***
i	***Craig Nunn — Senior Adjuster*** ***Phone: 530-768-4801 Email: craig.nunn@yorkrsg.com***
i	***Marcus Beverly — First Vice President, CPCU, AIC, ARM-P*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
i	***Michelle Minnick — Assistant Account Manager*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***

Client Responsibilities for Reporting Claims

i

- Members are required to notify ERMA within 30 days upon receipt of notice of a Claim by completing the Employment Risk Management Authority (ERMA) initial Report Form (see next page) and submitting to:
  Lance Gerber — Legal Analyst
  Email: *info@ermajpa.org*
  Please attach a copy of all Governmental Tort Claim, DFEH and/or EEOC documents you have regarding this claim or occurrence.

- Please be sure to forward a copy of the notice to Alliant Staff as well as York Risk Services at: *NCalYorkLiabilityClaims@yorkrsg.com*

Cameron L. Dewey, Unit Manager	530-768-7385
Craig Nunn, Sr. Claims Representative	530-768-4801
York Answering Service	916-971-2701

EMPLOYMENT RISK MANAGEMENT AUTHORITY (ERMA)

INITIAL REPORT FORM

In order to assist ERMA in monitoring claims and maintaining reserves, please fill out the following form for each claim or occurrence that is required to be reported to ERMA. Please answer each item as completely as possible with the information available to you. Use additional sheets as necessary. **Please attach to this form a copy of all Governmental Tort Claim, DFEH and/or EEOC, and internal or external complaint/investigation documents you have regarding this claim or occurrence.** Assignments to defense counsel will be made through ERMA after consultation with the ERMA member. If you have any questions, please call the ERMA office at (800) 541-4591.

1. Name of organization:_____
2. Name(s) of claimant:_____
3. Claimant's job title: _____
4. What is the claimant's employment status (current/terminated/paid or unpaid leave/suspended)? If terminated/ on leave or suspended, please include date:_____
5. Claimant's yearly salary and date of hire:_____
6. Complaint submitted? _____

   If written, please provide date of complaint and attach a copy:_____

   If verbal, please provide date and name/title of the person the complaint was reported to:
   _____
7. DFEH complaint filed? _____ If yes, date of filing:_____

   Date of DFEH Right to Sue Letter (if received):_____
8. EEOC complaint filed? _____ If yes, date of filing:_____

   Date of EEOC Right to Sue Letter (if received):_____
9. Governmental tort claim filed? _____ If yes, date of filing:_____

   Date and form of response to tort claim_____
10. Date of first incident underlying the complaint:_____
11. Brief factual summary: _____
_____
_____
_____
_____
_____
_____
12. Demand by Claimant: _____

EMPLOYMENT RISK MANAGEMENT AUTHORITY
(ERMA)

INITIAL REPORTING REQUIREMENTS

Pursuant to ERMA's Memorandum of Coverage effective July 1, 2008, all ERMA members are required to notify ERMA within 30 days upon receipt of notice of a *Claim.* Written notice containing particulars sufficient to identify the claimant(s), the *Covered Party(ies),* and also reasonably obtainable information with respect to the circumstances of the *Claim*, as well as the names and addresses of the *Covered Party(ies)* and of available witnesses, shall be given to ERMA or any of its authorized agents as soon as possible. The form opposite this notice should be used to report claims to ERMA.

In addition to the above, if a suit is brought against a *Covered Party(ies),* the *Covered Party(ies)* is also obligated to forward immediately to ERMA every demand, notice, summons, or other process received by it or its representative.

If you have any questions regarding reporting to ERMA, please call the ERMA office at (800) 541-4591.

SCORE MEMBER PARTICIPATION FY 18/19

City of Biggs
City Of Colfax
City Of Dunsmuir
City Of Etna
Town Of Fort Jones
City Of Isleton
City Of Live Oak
Town Of Loomis
City Of Loyalton
City Of Montague
City Of Mount Shasta
City Of Portola
City Of Rio Dell
City Of Shasta Lake
City Of Susanville
City Of Tulelake
City Of Weed
City Of Yreka

Travelers
401 Lennon Lane
Walnut Creek, CA 94598

SCORE
Small Cities Organized Risk Effort
A Joint Powers Authority

Policy Period
July 1, 2018 – June 30, 2019

Services Performed By:
Travelers Bond & Financial Products Claim Department

Services Performed For:
Small Cities Organized Risk Effort
2180 Harvard Street STE 460
Sacramento, CA 95815

Crime – Identity Fraud Claims Contacts

ⓘ	***Travelers Bond & Financial Products Claim Department*** ***Phone: 800-842-8496 Email: Bondclaimsidfraud@travelers.com***
ⓘ	***Marcus Beverly — First Vice President, CPCU, AIC, ARM-P*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
ⓘ	***Michelle Minnick — Assistant Account Manager*** ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***

Client Responsibilities for Reporting Claims

ⓘ

- To file a claim under the Master Policy (#106526214) please contact:
  Travelers Bond & Financial Products Claim Department
  Phone: 800-842-8496
  Email: *Bondclaimsidfraud@travelers.com*

Program Administration Contact Information

MICHAEL SIMMONS
VICE CHAIRMAN, PUBLIC ENTITIES

Tel 415-403-1425
Cell 925-708-3374
msimmons@alliant.com

MARCUS BEVERLY
FIRST VICE PRESIDENT

Tel 916-643-2704
Fax 916-643-2750
Marcus.Beverly@alliant.com

MICHELLE MINNICK
ASSISTANT ACCOUNT MANAGER

Tel 916-643-2715
Fax 916-643-2750
Michelle.Minnick@alliant.com

Company Information

SCORE Program Administrators
Alliant Insurance Services, Inc.
2180 Harvard Street, Suite 460 Sacramento, California 95815
Tel (916) 643-2700
Fax (916) 643-2750
www.alliantinsurance.com
Corporate License No. 0C36861

National Flood Insurance Program

P.O. Box 33003
St. Petersburg, FL 33733-8003

SCORE
Small Cities Organized Risk Effort
A Joint Powers Authority

Policy Period

November 17, 2018 – November 17, 2019

Services Performed By:

National Flood Insurance Program

Services Performed For:

City of Live Oak (member of Small Cities Organized Risk Effort)
2180 Harvard Street STE 460
Sacramento, CA 95815

Flood – Claims Contacts

National Flood Insurance Program ***Phone: 800-725-9472***
Marcus Beverly — First Vice President, CPCU, AIC, ARM-P ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2704 Email: Marcus.Beverly@alliant.com***
Michelle Minnick — Assistant Account Manager ***2180 Harvard Street STE 460, Sacramento, CA 95815*** ***Phone: 916-643-2715 Email: Michelle.Minnick@alliant.com***

Client Responsibilities for Reporting Claims

- To file a claim first please call **Phone: 800-725-9472**

In case of a flood loss to insured property, you must:

- Notify us or your agent, in writing, as soon as possible after the flood.
- As soon as possible, separate damaged property from undamaged property so that damage can be inspected and evaluated.
- To help the claims adjuster, take photographs of the outside of the premises showing the flooding and the damage and photographs of the inside of the premises showing the height of the water and the damaged property.
- Prepare an inventory of damaged property showing the quantity, description, actual cash value, and amount of loss. Attach all bills, receipts, and related documents. Place all account books, financial records, receipts, and other loss verification material in a safe place for examination & evaluation by the claims adjuster.
- Within 60 days after the loss, send us a proof of loss, which is your statement of the amount you are claiming under the policy signed and sworn to by you, and which furnishes us with the following information:
  a. The date and time of loss;
  b. A brief explanation of how the loss happened;
  c. Your interest (for example, "owner") and the interest, if any, of others in the damaged property;
  d. Details of any other insurance that may cover the loss;
  e. Changes in title or occupancy of the insured property during the term of the policy