EMPLOYERS' NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by

Insurer (Or Insurance Company)
Global Casualty Company

Street and Number
888 Asylum Street

City | State | Zip Code
Hartford | **CT** | **06543**

For the period from **10/1/2007** through **10/1/2008**

Alaska Adjusting Company
Gallagher Bassett Services

Street and Number
Two Pierce Place

City | State | Zip Code | Telephone
Itasca | **IL** | **60143-3141** | **630.773.3800**

This insurance pays benefits for job-connected injuries, illnesses or death as provided by the Alaska Workers' Compensation Act.

Employer
Sample Corporation

By
Ronald T. Waxmen *Official Signature*

Title
HR Director

Witness
Frank Banks

Witness
Skip Stevens

Immediately (not later than 30 days from injury or death date) give your employer and the Alaska Workers' Compensation Board written notice of a job-related injury, illness, or death. Get the "Report of Occupational Injury or Illness" form from your employer for this purpose.

If you have questions about your rights or benefits under the Alaska Workers' Compensation Act, contact the insurer at the above address and the Alaska Workers' Compensation Board at the nearest office listed below:

ANCHORAGE
3301 Eagle Street
Box 107019
Anchorage, AK 99510-7019
(907) 269-4980

FAIRBANKS
675 Seventh Avenue
Station H2
Fairbanks, AK 99701-4593
(907) 451-2889

JUNEAU
1111 West 8th Street
Box 25512
Juneau, AK 99802-5512
(907) 465-2790

NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.

STATE OF ALABAMA
WORKERS' COMPENSATION
INFORMATION

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER

Global Casualty Company

TELEPHONE NUMBER

800-555-1212

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE. FOR INFORMATION CALL:

1-800-528-5166
Department of Industrial Relations
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131

CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS. FORM WCC#1 9/96

Form AR-P	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 Little Rock Office - 1-800-622-4472 / 501-682-3930 Ft. Smith Office - 1-800-354-2711/ 479-783-7970 Springdale Office - 1-800-852-5376 / 479-751-2790	**P**
Ark. Code Ann. §11-9-403, 407 AWCC Rule7 Updated: 04-15-02		

WORKERS' COMPENSATION INSTRUCTIONS TO EMPLOYERS AND EMPLOYEES

All employees of this establishment entitled to benefits under the provisions of the Arkansas workers' compensation laws are hereby notified that their employer has secured the payment of such compensation as may at any time be due employees or their dependents. This employer is required by state law to provide workers' compensation coverage or this employer has waived the exclusion or exemption from the operation of the workers' compensation laws, and the employer certifies by the display of this poster that workers' compensation coverage is now provided by a workers' compensation insurance policy or by enrollment in the Arkansas Self-Insurance Program or by the Public Employee Claims Division of the Arkansas Insurance Department.

Insurer's Name: Global Casualty Company

Claims Office Address: Two Pierce Place
Itasca, IL 60143-3141

Claims Office Phone: 630.773.3800

Policy Expiration Date: 10/1/2008

IN CASE OF JOB-RELATED INJURIES OR OCCUPATIONAL DISEASES

The Employer Shall:

1. Provide all necessary medical, surgical and hospital treatment, as required by law, following the injury and for such additional time as ordered by the Workers' Compensation Commission.
2. Provide compensation payments in accordance with the provisions of the law. The first installment of compensation becomes due on the 15th day after the employer has notice of the injury or death, except in those cases where liability has been denied by the employer.
3. Provide prompt reporting of accidents to appropriate parties.
4. Keep a record of all injuries received by its employees.

The Employee Shall:

The employee shall report the injury to the employer on Form N and to a person or at a place specified by the employer, unless the injury either renders the employee physically or mentally unable to do so, or the injury is made known to the employer immediately after it occurs. The employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's notice of injury. All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements. The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

Failure to give such notice shall not bar any claim (1) if the employer had knowledge of the injury or death, (2) if the employee had no knowledge that the condition or disease arose out of and in the course of employment, or (3) if the Commission excuses such failure on the grounds that for some satisfactory reason such notice could not be given. Objection to failure to give notice must be made at or before the first hearing on the claim.

Statutory Information:

Ark. Code Ann. § 11-9-514(b) states: "Treatment or services furnished or prescribed by any physician other than the ones selected according to the foregoing, except emergency treatment, shall be at the claimant's expense."

Ark. Code Ann. § 11-9-514(f), however, indicates: When compensability is controverted, subsection (b) shall not apply if:

(1) The employee requests medical assistance in writing prior to seeking the same as a result of an alleged compensable injury; and

(2) The employer refuses to refer the employee to a medical provider within forty-eight (48) hours after such written request as provided above; and

(3) The alleged injury is later found to be a compensable injury; and

(4) The employer has not made a previous offer of medical treatment.

If you have any questions regarding your rights under the Arkansas workers' compensation laws, you may call an Arkansas Workers' Compensation Commission legal advisor at our toll-free number listed above.

All employers who come within the operation of the Arkansas workers' compensation laws and have complied with its provisions must post this notice in a **CONSPICUOUS** place in or about their place or places of business.

Formulario AR-P	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS	P
Autoridad: Ark. Code Ann., apartado 11-9-403, 407 AWCC, Norma 7 Actualizado: 04-15-2002 En Español: 10-15-2004	324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 Oficina de Little Rock: 1-800-622-4472 / 501-682-3930 Oficina de Ft. Smith: 1-800-354-2711 / 479-783-7970 Oficina de Springdale: 1-800-852-5376 / 479-751-2790	

INSTRUCCIONES SOBRE LA COMPENSACIÓN DE LOS TRABAJADORES PARA EMPLEADORES Y EMPLEADOS

Todos los empleados de este centro que tengan derecho a beneficiales en virtud de lo dispuesto en la legislación de compensación de los trabajadores son informados en virtud del presente documento de que su empleador ha organizado el pago de las compensaciones que puedan tener que abonarse a los empleados o sus dependientes. Este empleador debe, en virtud de la legislación estatal, ofrecer a sus empleados cobertura por compensaciones o ha renunciado a la exención o exclusión de la ejecución de la legislación en materia de compensaciones a los trabajadores y certifica mediante la muestra de este cartel que en la actualidad ofrece cobertura a sus trabajadores dentro de una póliza de seguro de compensación de los trabajadores o por su participación en el Programa de Auto-seguros de Arkansas o la División Pública de Reclamaciones de los Empleados del Departamento de Seguros de Arkansas.

Nombre de la Compañia de Seguros: Global Casualty Company
Dirección de la Oficina de Reclamaciones: Two Pierce Place
Itasca, IL 60143-3141
Número de Teléfono de Reclamaciones: 630.773.3800
la Fecha en que Expira la Póliza: 10/1/2008

EN CASO DE PRODUCIRSE UNA LESIÓN VINCULADA AL TRABAJO O UNA ENFERMEDAD PROFESIONAL

El empleador deberá:

1. Ofrecer todo el tratamiento médico, quirúrgico y hospitalario que sea preciso en virtud de la legislación, tras la lesión y durante el tiempo adicional que establezca la Comisión de Compensación de los trabajadores.
2. Ofrecer pagos de compensación de acuerdo con lo dispuesto en la legislación. El primer plazo vencerá al cabo de 15 días desde que el empleador sea informado de la lesión o fallecimiento, excepto en los casos en el empleador haya denegado su responsabilidad.
3. Informar inmediatamente de los accidentes a los interesados.
4. Mantener un registro de todas las lesiones de las que sea informado por sus empleados.

El empleado deberá:

El empleado deberá informar de la lesión al empleador en el formulario N y a una persona o en un lugar indicado por este último, a menos que se trate de una lesión que impida mental o físicamente al empleado hacerlo o si la lesión se comunica al empleador inmediatamente después de producirse. El empleador no será responsable de las beneficiales de discapacidad, médicas o de otro tipo anteriores a la recepción del informe del accidente. Todos los procedimientos de notificación que especifique el empleador deberán ser razonables y éste deberá notificar razonablemente a todos los empleados los requisitos de notificación. Lo anterior no será de aplicación si el empleado precisa tratamiento médico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado deberá hacer que se notifique el accidente al empleador el siguiente día laborable habitual.

La falta de notificación no anulará las reclamaciones si: (1) El empleador tiene conocimiento del fallecimiento o lesión; o (2) El empleado no tenía conocimiento de que la afección o enfermedad se produjo en el transcurso de su empleo; o (3) La Comisión exime esta omisión basándose en que la notificación no pudo realizarse por un motivo justificado.
Las objeciones relativas a la falta de notificación deberán plantearse antes o en el momento de celebrarse la primera vista de la reclamación.

Información legal:

El artículo 11-9-514(b) del Ark. Code Ann. establece que: "El tratamiento o los servicios prestados por un médico distinto de los seleccionados de acuerdo con lo anterior, con excepción de los tratamientos urgentes, correrán a cargo del demandante."
El artículo 11-9-514(f) del Ark. Code Ann., sin embargo, establece que: Cuando la compensación sea causa de controversia, el subapartado (b) no será de aplicación si:
(1) El empleado solicita asistencia médica por escrito antes de buscarla como consecuencia de una posible lesión compensable; y
(2) El empleador se niega a remitir al empleado a un proveedor médico en el plazo de cuarenta y ocho (48) horas desde dicha solicitud escrita; y
(3) Posteriormente se descubre que la supuesta lesión es compensable; y
(4) El empleador no ha hecho ninguna oferta anterior de tratamiento médico.

Si tiene alguna pregunta relativa a sus derechos en virtud de la legislación en materia de compensaciones de los trabajadores de Arkansas, puede llamar al asesor legal de la Comisión de Compensación de los Trabajadores de Arkansas al número gratuito que se indica más arriba.

Todos los empleadores que se vean afectados por la ejecución de la legislación en materia de compensaciones de los trabajadores de Arkansas y que hayan cumplido estas disposiciones deberán colocar esta notificación en un lugar **PREEMINENTE** en su centro de trabajo o las cercanías.

Form AR-H	ARKANSAS WORKERS' COMPENSATION COMMISSION	H
Authority: Ark. Code Ann. § 11-9-514, AWCC Rule 7, 33 Revised 1-1-2001	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

HEALTH CARE NOTICE FOR EMPLOYEES UNDER MANAGED CARE

Your employer has contracted with the following **M**anaged **C**are **O**rganization (**MCO**):

Name **United Health Care**

Address **4102 State ST, Floor 7**
Orem, UT 84051

or has been certified as an **I**nternal **M**anaged **C**are **S**ystem (**IMCS**). ***You are required to receive treatment through this MCO/IMCS if you receive a work-related injury. If you do not receive treatment through this MCO/IMCS, or you do not obtain permission to change treatment provider(s), then you may be required to pay for the treatment you receive***. Emergency treatment is exempt from this requirement.

Employees are covered under the MCO/IMCS ***after*** the employer posts Form H. Prior notice given to employees by a certified MCO shall fulfill the above notice requirements.

The telephone number of your employer's MCO/IMCS is **801.631.1100**. You may call this number if you have questions about managed care or if you need names of physicians.

If you are injured on the job, you should notify your supervisor immediately. Your supervisor will arrange for treatment or explain what you need to do to receive treatment for your injury.

If you have a problem with or a dispute about this MCO/IMCS, you may file a complaint within thirty (30) days of the occurrence. To obtain information contact your supervisor, the MCO/IMCS, or the Medical Cost Containment Division at the AWCC (1-800-622-4472 or 501-682-3930).

If you are balance billed by a physician for a covered workers' compensation injury, you should notify your employer. Balance billing occurs when physicians are paid according to the MCO/IMCS contract or the Arkansas Workers' Compensation Fee Schedule, the amount they were paid is less than the amount of their bill, and they attempt to collect the difference from employees.

Choice/change of physician is controlled by law. Your employer may choose the initial treating physician. Any referral would be to parties abiding by MCO rules, terms, and conditions. Emergency medical treatment is exempted. If you want a change of physician, request it from the insurance carrier or employer. If the decision is unsatisfactory, you may petition the Commission for a change. "[T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions. Such optometric or ophthalmologic medical service provider shall be considered a certified provider by the commission." Ark. Code Ann. § 11-9-508(e) ***Treatment or services furnished or prescribed other than according to the above, EXCEPT EMERGENCY TREATMENT, shall be at your own expense***.

TO BE POSTED BY EMPLOYER

POLICY NUMBER: WCAI_571971

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with:

Global Casualty Company
(Insurance Company Name)

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

PARA SER COLOCADO POR EL PATRON

NUMERO DE POLIZA: WCAI_571971

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patrón ha cumplido con las provisiones de la Ley de Compensación para los Trabajadores de Arizona (Título 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las regias y ordenanzas de La Comisión Industrial de Arizona hechas en cumplimiento de ésta, y ha asegurado el pago de compensación a los empleados garantizando el pago de dicha compensatión a los empleados garantizando el pago de dicha compensación por medio de;

Global Casualty Company
(Insurance Company Name)

Además, a todos los empleados se les notifica por este medio que en caso de que especificamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerará bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensación bajo estos términos; también bajo estos términos los empleados tienen el derecho de rechazar la misma por medio de una notificación por escrito antes de que sufran alguna lesión, todos los formularios o formas en blanco para tal notificación por escrito estarán disponibles para todos los empleados en la oficina de este patrón.

KEEP POSTED IN A CONSPICUOUS PLACE
COLOQUESE EN LUGAR VISIBLE

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

RE: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluids(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5188. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

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. For injuries occurring on or after 1/1/04, there is a limit on some medical services.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering.
- **Permanent Disability (PD) Benefits:** Payments if your injury causes a permanent disability.
- **Vocational Rehabilitation:** Services and payments if your injury prevents you from returning to your usual job or occupation. This benefit applies to injuries that occurred prior to 1/1/04.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher payable to a state approved school if you are injured on or after 1/1/04, the injury results in a permanent disability, you don't return to work within 60 days after TD ends, and your employer does not offer 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. You may be able to choose the doctor who will treat you for a job injury or illness during the first 30 days after the injury . If eligible, you must tell your employer, in writing, the name and address of your personal physician *before* you are injured. For instructions, see the written information about workers' compensation that your employer is now required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need first aid, contact your employer. If you need emergency care, call for help immediately. Emergency phone numbers:

   Ambulance 911 Fire Dept. 911 Police 911

   Doctor 911 Hospital 911

2. **Report Your Injury.** Report the injury immediately to your supervisor or to:
   Employer representative Ronald T. Waxmen phone number 253.630.1111.
   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 an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness. If you named your personal physician 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. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. Contact your employer for more information.

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 Gallagher Bassett Services

Address Two Pierce Place City Itasca State IL Zip 60143-3141

Phone 630.773.3800 Policy Expiration Date 10/1/2008

The employer is insured for workers' compensation by Global Casualty Company
(Enter "self-insured" if appropriate)

If the workers' compensation policy has expired, contact a Labor Commissioner at the Division of Labor Standards Enforcement - their number can be found in your local White Pages under California State Government, Department of Industrial Relations.

You can get free information from a State Division of Workers' Compensation Information & Assistance Officer.
The nearest Information & Assistance Officer is at:

Address 455 Golden Gate Avenue, 2nd floor City San Francisco Phone (415) 703-5020

Hear recorded information and a list of local offices by calling toll-free **(800) 736-7401**. Learn more online: **www.dir.ca.gov.**

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.

DWC 7 (8/1/04)

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
Division De Compensación Al Trabajador

Aviso a los Empleados—Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación para trabajadores, si usted se lesiona o se enferma a causa de su trabajo. La compensación para 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 para trabajadores incluyen:

- **Atención Médica:** Consultas con el médico, 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. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos, si usted pierde sueldos, mientras se recupera.
- **Beneficios por Incapacidad Permanente (PD):** Pagos, si su lesión le ocasiona una incapacidad permanente.
- **Rehabilitación Vocacional:** Servicios y pagos, si su lesión no le permite regresar a su empleo u ocupación normal. Este beneficio para lesiones que ocurrieron antes de 1/1/04.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Une vale no-transferible pagadero a una escuela aprobada por el estado si se lesiona en o después de 1/1/04, la lesión le ocasiona una incapacidad permanente, no regresa al trabajo en un plazo de 60 días después que los pagos por incapacidad temporal terminan, y su empleador no le ofrece un trabajo modificado o alterno.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muera a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión. Es posible que usted pueda elegir al médico que le atenderá a causa de una lesión o enfermedad relacionada con el trabajo durante los primeros 30 días después de la lesión. Si elegible, usted tiene que decirle al empleador, por escrito, el nombre y la dirección de su médico personal, *antes* de que usted se lesione. Para instrucciones, vea la información escrita sobre la compensación para trabajadores, que ahora se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita primeros auxilios, comuníquese con su empleador. Si usted necesita atención de emergencia, pida ayuda inmediatamente. Los números de teléfono de emergencia son:

   Ambulancia 911 Dept. de Bomberos 911 Policía 911

   Doctor 911 Hospital 911

2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a:
   El/la representante del empleador Ronald T. Waxmen Número de teléfono 253.630.1111.
   No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. A su empleador se le exige proporcionarle un formulario de reclamo, en un plazo de un día laboral, a partir de que sepa lo referente a su lesión. El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento applicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares ($10,000).

3. **Consulte al Médico Primario que le Atienda (PTP).** Este es el médico con toda la responsabilidad para dar el tratamiento para su lesión o enfermedad. Si usted designó a su médico personal antes de la lesión (vea uno de los párrafos anteriores), usted puede consultarlo para el tratamiento en ciertas circunstancias. De otra forma, su empleador tiene derecho a seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar al médico de su preferencia después de 30 días. Hay reglas especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o depués de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información.

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 atestiguar en el caso de compensación para trabajadores de otra persona. Si es probado, puede ser que usted reciba pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

¿Preguntas? Obtenga más información sobre la compensación para trabajadores, leyendo la información que ahora se le exige a su empleador darle a los empleados nuevos. Si usted tiene preguntas, vea a su empleador o al/a la administrador(a) de reclamos (que maneja los reclamos de compensación para trabajadores por su empleador):

Administrador(a) de Reclamos Gallagher Bassett Services

Dirección Two Pierce Place Ciudad Itasca Estado IL Código postal 60143-3141

Teléfono 630.773.3800 Fecha de Vencimiento de la Póliza 10/1/2008

El empleador está asegurado para compensación para trabajadores con Global Casualty Company
(Anote "autoasegurado" si es pertinente)

Si la póliza de compensación para trabajadores se ha vencido, comuníquese con el Comisionado del Trabajo, en la Division of Labor Standards Enforcement. Su número puede encontrarse en las Páginas Blancas de su guía telefónica local, bajo el encabezado en inglés de *California State Government, Department of Industrial Relations.*

Usted puede obtener información gratuita de un Oficial de Asistencia e Información, de la División de Compensación al Trabajador. El Oficial de Asistencia e Información más cercano se localiza en:

Dirección 455 Golden Gate Avenue, 2nd floor Ciudad San Francisco Teléfono (415) 703-5020

Usted puede escuchar información grabada, y una lista de las oficinas locales, llamando al número gratuito **(800) 736-7401**.
Usted puede obtener más información en el Internet en: **www.dir.ca.gov.** Enlácese a la sección de Compensación para Trabajadores.

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación relevante intencionalmente falsa o fraudulenta, con el fin de obtener, o negar beneficios o pagos de compensación para trabajadores, es culpable de un delito grave y puede resultar en una multa y encarcelación.

Es posible que su empleador o asegurador no sea responsible por el pago de beneficios de compensactión laboral debido a una lesión causada por la participación voluntaria del empleado en cualquier **actividad recreativa, social, o atlética** fuera del trabajo que no sea parte de los deberes laborales del empleado.

DWC 7 (8/1/04)

WORKERS' COMPENSATION ACT

LEY DE LA COMPENSACIÓN DE LOS TRABAJADORES

NOTICE TO EMPLOYEES

AVISO A LOS EMPLEADOS

Your employer is insured under the above-named law by: Global Casualty Company
Su empleador está asegurado bajo está ley por: Global Casualty Company

If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT. If you fail to report your injury or occupational disease promptly, Loss of Benefit penalties may be assessed against you.

No compensation is payable for the first 3 days' disability unless the period of disability exceeds two weeks. Thereafter, the compensation rate while disabled is 2/3 of your average weekly wage, subject to a statutory maximum determined annually as provided by law.

You are entitled to reasonable and necessary medical, surgical and hospital treatment for treatment of injuries or occupational diseases. In all cases of injury, the employer or insurer has the right in the first instance to select the physician. If a physician is not designated by the employer or insurer, you may select the services of a licensed physician or chiropractor.

You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S.

The physicians designated by your employer's insurance carrier are:

In addition to any reports the employer is required to file, an injured employee may file his own claim for compensation and medical benefits in order to protect his future rights. To obtain claim forms or if your compensation is not paid promptly during your disability, or if you wish any information concerning your rights under the Workers' Compensation Act, write the Colorado Division of Workers' Compensation, 633 17th Street, Suite 400, Denver, CO, 80202-3660, giving your name as it appears on the payroll, your social security number, the name of your employer, and the date of your accident. To obtain further information you may call Customer Service at 303.318.8700.

Si usted se lastimada o contrae una enfermedad en el trabajo, es posible que tenga derecho a beneficios de compensación según la ley. AVISE USTED POR ESCRITO A SU EMPLEADOR DENTRO CUATRO DÍAS DEL ACCIDENTE. Si no informa su lastimadura a su empleador existe la posibilidad que no reciba los beneficios de la ley.

No se pagarán beneficios por los tres primeros días de incapacidad, a menos que el periodo de incapacidad dure más de dos semanas. Después de las dos semanas, el valor de los beneficios, mientras el trabajador continue incapacitado será 2/3 del salario seminal promedio, sujeto a un máximo fijado cada año por la ley.

El trabajador tiene el derecho de recibir servicios médicos, cirugía, o hospitalización para las lastimaduras o enfermedades. Para todas las lastimaduras el empleador o la compañía de seguros tiene el derecho en la primera instancia a seleccionar el medico. Si la compañía de seguros no ha designado un médico representando su empleador, usted puede selecionar los servicios de un médico titulado o un quiropráctico.

Por este medio, se le notifica que si usted debe alimentos para menores, los beneficios de compensación pueden ser incluidos y el pago puede ser retenido y enviado a quien corresponde según las secciones C.R.S. 8-42-124 y 26-13-122(4).

Los médicos escogidos por la compañía de seguros de su empleador son:

Además de los informes que el empleador debe archivar, el empleado lesionado puede archivar su propio informe para recibir beneficios médicos, y proteger sus derechos futuros. Para obtener los papeles necesarios (formas) o reclamar los beneficios de los pagos puntuales durante el tiempo que usted este incapacitado, o si necesita más información, sobre la ley de compensación, se pone en contacto con la División de la Compensación de los Trabajadores o escriban a: Colorado Division of Workers' Compensation, 633 17th Street, Suite 400, Denver, CO, 80202-3660. Al solicitar qualquier información favor de incluir: su nombre como está registado con su empleador, su número de seguro social, el nombre y la dirección de su empleador, y la fecha del accidente. Para obtener más información pueden llamar 303.318.8700 o sin peaje 1.800.685.0891.

COLORADO DIVISION OF WORKERS' COMPENSATION
633 17TH STREET, SUITE 400, DENVER, CO 80202-3660

WARNING

IF YOU ARE INJURED ON THE JOB, WRITTEN NOTICE OF YOUR INJURY MUST BE GIVEN TO YOUR EMPLOYER WITHIN FOUR WORKING DAYS AFTER THE ACCIDENT, PURSUANT TO SECTION 8-43-102(1) AND (1.5), COLORADO REVISED STATUTES.

IF THE INJURY RESULTS FROM YOUR USE OF ALCOHOL OR CONTROLLED SUBSTANCES, YOUR WORKERS' COMPENSATION DISABILITY BENEFITS MAY BE REDUCED BY ONE-HALF IN ACCORDANCE WITH SECTION 8-2-112.5, COLORADO REVISED STATUTES.

AVISO

SI SE LASTIMA EN EL TRABAJO, DEBE DARLE UN AVISO POR ESCRITO A SU EMPLEADOR DENTRO DE CUATRO DÍAS LABORABLES DEL ACCIDENTE, SEGÚN A LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-43-102(1) Y (1.5).

SI EL ACCIDENTE RESULTA DEBIDO AL USO DE ALCOHOL O UNA SUSTANCIA CONTROLADA, SUS BENEFICIOS DE LA INCAPACIDAD DE LA COMPENSACIÓN DE LOS TRABAJADORES PUEDEN SER REDUCIDOS POR UN MEDIO EN CUERDO DE LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-42-112.5.

State of Connecticut Workers' Compensation Commission

Notice to Employees

Workers' Compensation Act

Chapter 568 of the Connecticut General Statutes (the Workers' Compensation Act) requires your employer,

Sample Corporation

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states: "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer." Such an injury report by the employee is NOT an official written notice of claim for workers' compensation benefits. (The Form 30C is necessary to satisfy this requirement.)

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name Global Casualty Company

Address 888 Asylum Street Telephone 800-555-1212

City/Town Hartford State CT Zip Code 06543

Approved Medical Care Plan ☐ Yes ☒ No

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address 44 Main Street Telephone 203-888-9933

City/Town Stamford State CT Zip Code 06905

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company or the Workers' Compensation Commission (1-800-223-9675).

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted _____

DISTRICT OF COLUMBIA GOVERNMENT
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION

PO BOX 56098 • WASHINGTON, DC 20011 • (202) 671-1000 • (202) 671-1929 (fax)

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

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law to report promptly to your employer and the Office of Workers' Compensation an occupational injury or disease, even if you deem it to be minor. Form No. 7 DCWC, Notice of Accidental Injury or Occupational Disease, to be obtained from the employer or the Office of Workers' Compensation, must be used for that purpose. After you have completed and signed it, you should mail it to the Office of Workers' Compensation at the above address, and to your employer.

2. You are entitled, if required, to the services of a physician or hospital of your choice and lost wages. Call (202) 671-1000 for information.

3. You may not sue your employer as a result of a work-connected injury or disease by reason of your exclusive remedy under the Workers' Compensation Law.

4. In order to preserve your right to benefits under the DC Workers' Compensation Law, you must file a written claim on Form No. 7A DCWC, Employee's Claim Application, within one (1) year after your injury, or within (1) year after the last payment of benefits.

5. If you desire information regarding your rights and obligations prescribed by law, you may call your employer first. If you need further information you may call the Office of Workers' Compensation at (202) 671-1000.

6. The law gives you the right to be represented if you so desire.

TO EMPLOYERS

1. You are required to have Workers' Compensation insurance coverage if you have 1 or more employees.

2. You are required to display this poster at each worksite so that it will be of the greatest possible benefit to your employees.

3. You must file an Employer's First Report of Injury or Occupational Disease, Form No. 8 DCWC, with the Office of Workers' Compensation, copy to the nearest claim office of your insurer, on all occupational injuries or disease, as soon as possible, but no later than 10 days after the date of knowledge thereof.

4. Your employee must file Form No. 7 DCWC, Employee's Notice of Accidental Injury or Occupational Disease. Please provide your employee with Form No. 7 DCWC and direct them to complete it and return it to you and the Office of Workers' Compensation. Once you have received notice from the employee, you are required to send the employee a notice of his/her rights and obligations by certified mail, return receipt requested.

5. You are required to report to the Office of Workers' Compensation, and your insurer, and disability of more than 3 days which was not previously reported, as soon as possible, but no later than 10 days after the date of knowledge thereof.

6. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee.

7. You are required to obtain from the insurer identified below a supply of all required Workers' Compensation Forms, or you may download the forms and notice mentioned above at our website http://does.dc.gov

NOTICE: Violation of the various provisions of the Workers' Compensation law provides for civil penalties.

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations

NAME OF INSURANCE COMPANY

Global Casualty Company
888 Asylum Street
Hartford, CT 06543
800-555-1212

NAME OF EMPLOYER

BY Sample Corporation

987654321
Employer ID Number
(if number unknown, employer to request from IRS)

THIS NOTICE IS TO BE POSTED CONSPICUOUSLY IN AND ABOUT EMPLOYER'S PLACE(S) OF BUSINESS

FORM NO. 1 DCWC Revised June, 2002

WORKERS' COMP WORKS FOR YOU

$25,000 Reward

Anti-Fraud Reward Program

Rewards of up to $25,000 may be paid to persons providing information to the Department of Insurance leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the department at 1-800-378-0445.
A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.

Workers' compensation pays your medical bills and other expenses and replaces part of your salary if you are injured while working.

You should expect if you are unable to work for more than seven days to be compensated for a portion of your lost wages, limited to the maximum as set by law.

This Notice of Compliance must be posted by the employer and maintained conspicuously in and about the employer's place or places of employment.
State of Florida-Division of Workers' Compensation.

If you are injured on the job:

1. Notify your employer immediately to get the name of an approved physician. Workers' comp insurance may not pay the medical bills if you don't let the employer know you have been injured.

2. Remind the doctor and medical staff that you are covered under workers' comp.

3. If you have any problems with your claim or suffer excessive delays in treatment, contact the Division of Workers' Compensation at 1-800-342-1741.

Employer Name:	**Sample Corporation** **432 Park Ave.** **New York, NY 10020**
Insurance Company:	**Global Casualty Company** **888 Asylum Street** **Hartford, CT 06543**
Agent/Broker:	**Marsh USA**
Policy Number:	**WCAI_571971**
Effective Date:	**10/1/2007**

La Compensación de los Trabajadores trabaja para usted

$25,000 de Recompensa

Programa de Recompensa Anti-Fraud

Recompensas de hasta $25,000 pueden ser pagadas a individuos que provean información que conduzca al arresto y convicción de personas que esten cometiendo fraude de seguro. Esto incluye fraude cometido por patrones que fallan en obtener cubierta obligatoria de compensación laboral. Reporte casos en los que sospeche fraudeal departamento al 1-800-378-0445.

Nadie está sujeto a responsabilidad civil por someter dicha información si se actúa sin malicia, fraude o mala fe.

El seguro de Compensación de los Trabajadores paga por sus gastos médicos y otros gastos y le remplaza parte de su salario si usted se accidenta mientras está trabajando.

Lo que debe esperar si no puede trabajar por más de siete días, es ser compensado por una porción de su salario perdido, hasta un máximo establecido por ley.

El patrono debe fijar este aviso de cumplimiento a la vista de todos en el lugar o lugares de trabajo.
Estado de la Florida-Division de la Compensación de los Trabaiadores.

Si usted se accidenta en el trabajo:

1. Notifique a su patrono inmediatamente para que obtenga el nombre de un doctor autorizado. El seguro de la Compensación de los Trabajadores podría no pagarle por sus gastos médicos si usted no le informa a su patrono que ha tenido un accidente.

2. Avísele al doctor y al personal médico que usted está cubierto bajo el seguro de compensación de los trabajadores.

3. Si tiene algún problema con su reclamo o si tiene demasiadas demoras en su tratamiento,comuníquese con la División de Compensación de los Trabajadores al 1-800-342-1741.

Employer Name:	**Sample Corporation** **432 Park Ave.** **New York, NY 10020**
Insurance Company:	**Global Casualty Company** **888 Asylum Street** **Hartford, CT 06543**
Agent/Broker:	**Marsh USA**
Policy Number:	**WCAI_571971**
Effective Date:	**10/1/2007**

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.

2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.

3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job.

4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.

5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $500 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-3818.

6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $500 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $334 per week, not to exceed 350 weeks.

7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $334 per week for no longer than 350 weeks.

8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $500 per week. A widowed spouse with no children will be paid a maximum of $150,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.

9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.

2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.

3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.

4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.

5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.

6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.

7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.

8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.

9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.

10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.

11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.

12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: http://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-237-2629.

(7/2006)

JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

Derechos de los Empleados

1. **Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.**

2. **Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.**

3. **Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo.**

4. **Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que falto al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.**

5. **Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de $500 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-3818.**

6. **En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no mas de $500 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de $334 por semana, que no excedan 350 semanas.**

7. **Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no mas de $334 por semana pero no más de 350 semanas.**

8. **En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro $7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de $500 por semana. Una esposa viuda sin niños se le pagara un máximo de $150,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.**

9. **Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.**

Responsabilidades de los Empleados

1. **Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.**

2. **Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.**

3. **Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.**

4. **No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.**

5. **Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.**

6. **Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/ empleador de cambios de dirección o nuevo matrimonio.**

7. **Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.**

8. **Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.**

9. **Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.**

10. **Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.**

11. **Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.**

12. **Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de $10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.**

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: http://www.sbwc.georgia.gov. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-237-2629.

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. §34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682
http://www.sbwc.georgia.gov

Your employer has enrolled with the certified Workers' Compensation Managed Care Organization (WC/MCO) listed below to provide all the necessary medical treatment for workers' compensation injuries. The effective date is shown below. If you had an injury prior to the effective date listed below you may continue to receive treatment from your current non-participating authorized physician until you elect to utilize the services of the WC/MCO.

Each employee will be furnished with a publication which explains in detail how to access the services of the WC/MCO and provides a complete list of the medical providers available. In addition, each employee will be given a wallet-sized card which contains information on the services of the WC/MCO including a 24-hour toll-free phone number with recorded messages of information on how to utilize these services.

NAME OF WC/MCO **United Health Care**

MAILING ADDRESS **4102 State ST, Floor 7**
Orem, UT 84051

GEOGRAPHICAL SERVICE AREA **Entire State of Georgia**

NAME OF CONTACT PERSON **Victor Hugo**

PHONE NUMBER OF CONTACT PERSON **(414) 231-4410**

ADDRESS OF CONTACT PERSON **4102 State ST, Floor 7**
Orem, UT 84051

24-HOUR TOLL-FREE PHONE NUMBER **630.773.3800**

EFFECTIVE DATE OF WC/MCO **10/1/2007**

The insurance company providing coverage for this business under the Workers' Compensation Law is:

Global Casualty Company
Name

888 Asylum Street
Hartford, CT 06543
address

800-555-1212
phone

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

WC-P3 (7/2006)

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISARLE AL EMPLEADOR PERSONALMENTE, UN AGENTE, REPRESENTANTE, FEJE O CAPATAZ.

Si un trabajador se lesiona en el trabajo, el empleador debe pagar los gastos médicos y de rehabilitación dentro de los limites de la ley. En algunos casos el empleador también pagara una parte de los ingresos perdidos. Lesiones de trabajo y de enfermedades ocupacionales deben ser reportado por escrito cuando sea posible. El trabajador puede perder los derechos de recibir compensación si un accidente no es reportado dentro de 30 días (referencia O.C.G.A. §34-9-80). El empleador ofrecerá una planilla sin costo alguno cuando sea pedida para reportar accidentes y también sin costo alguno, puede suministrar información acerca de compensación de trabajadores. El empleador también suministrará, si es pedido, al empleado, copias de planillas de la junta archivadas con el empleador pertenecientes a reclamos de los empleados.

Junta Estatal de Compensación de Trabajadores
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-0682
404-656-3818
o 1-800-533-0682
http://www.sbwc.georgia.gov

Su empleador esta matriculado con la organización administrativa de cuidados de compensación de trabajadores (WC/MCO) inscrito abajo, para proveer todos los tratamientos médicos necesarios en lesiones de compensación de Trabajadores. El día efectivo aparece debajo. Si usted a tenido una lesión antes de la fecha efectiva inscrito abajo, usted puede continuar recibiendo tratamiento por su actual medico no-participante hasta que usted elija utilizar los servicios de WC/MCO.

Cada empleado se le proveerá una publicación la cual explica en detalles como adquirir los servicios de la (WC/MCO) y se le proveerá con una lista completa de los médicos proveedores disponibles. Y además, cada empleado recibirá una tarjeta tamaño billetera que contiene información de los servicios de la WC/MCO incluyendo un numero disponible las 24 horas con mensaje grabados con información de como utilizar los servicios.

NOMBRE DE WC/MCO **United Health Care**

DIRECCION **4102 State ST, Floor 7**
Orem, UT 84051

AREA DE SERVICIO GEOGRAFICO **Entire State Of Georgia**

NOMBRE DE PERSONA DE CONTACTO **Victor Hugo**

NUMERO DE TELEFONO DE PERSONA DE CONTACTO **(414) 231-4410**

DIRECCION DE PERSONA DE CONTACTO **4102 State ST, Floor 7**
Orem, UT 84051

NUMERO DE TELEFONO DE 24 HORAS **630.773.3800**

FECHA EFECTIVA DE WC/MCO **10/1/2007**

La compañía de seguro que provee cobertura para esta Empresa bajo
la Ley de Compensación de Trabajadores es:

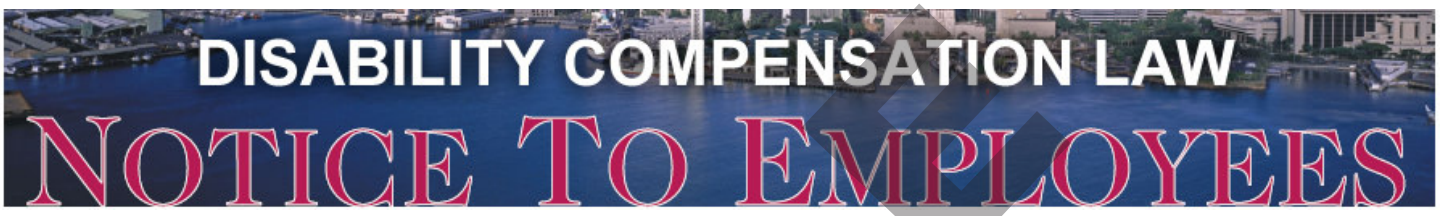
Global Casualty Company
Nombre

888 Asylum Street
Hartford, CT 06543 — **800-555-1212**
Dirección — Teléfono

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA SITIO WEB: http://www.sbwc.georgia.gov

HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPÓSITO DE OBTENER O NEGAR BENEFICIOS ES UN CRIMEN SUJETO A PENALIDADES DE HASTA 10,000.00 POR VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19.)

WC-P3 (7/2006)



Workers' Compensation - You have the right to receive workers' compensation benefits and medical care if you suffer a work-related injury. You must report the date, time and circumstance of your injury immediately to your employer or supervisor. Give the name of the insurer to your doctor so that your doctor will know where to send the physician's report. If your employer does not file a report of the injury, you may file a written claim with the Disability Compensation Division. You do not pay for the premium cost; your employer pays the entire amount.

You are entitled to all required medical, surgical and hospital services and supplies including medication; weekly benefits from the fourth day of disability to replace wage loss, representing 66 2/3% of your average weekly wage but not more than the maximum weekly benefit amount annually set by the Department; additional benefits if the injury results in permanent disability or disfigurement; vocational rehabilitation, if appropriate; funeral and burial expenses if the work injury results in death; and additional weekly benefits to the surviving spouse and other dependents.

Temporary Disability Insurance - You have the right to file a claim for temporary disability insurance benefits within 90 days from the date of disability if you suffer a disabling nonwork-related injury/illness, or inability to work because of your pregnancy. Your employer or insurance carrier should furnish you with a TDI-45 claim form or some other authorized claim form. You may receive TDI benefits if your inability to work is properly certified by a physician. Generally, you must have worked for an employer in Hawaii at least two weeks prior to your disability. During the last 52 weeks, you must have: worked for at least 14 weeks; been paid for at least 20 hours per week; and earned at least $400.

After a 7 consecutive day waiting period, you will be paid 58% of your average weekly wage, not to exceed the maximum in the TDI law. Your employer may have an "equivalent" plan approved by the Department, which may provide different benefits. You should ask your employer for details if they have an "equivalent" plan.

You may be required by your employer to share in the premium cost. Your share cannot be more than one-half of the cost and should not exceed .5% of your weekly wages. Your employer pays the remaining portion exceeding the prescribed limitation. If you are not eligible for benefits (see second paragraph above), your employer cannot deduct any contributions from you to share in the premium cost.

Prepaid Health Care - You have the right to enroll in your employer's prepaid health care insurance plan after 4 consecutive weeks of employment where you have worked at least 20 hours each week. The health care plan must be approved by the Department and include insurance coverage for hospital, surgical, medical, diagnostic and maternity medical care.
You should claim benefits under this program if a nonwork-related injury or illness requires medical care. Give your doctor or hospital the name of your employer's health care contractor and the plan name.

If you are required to share in the premium cost for your coverage, your share cannot be more than 1.5% of your monthly wages or one-half the premium cost (whichever is less). Your employer pays the balance.

Disability Compensation Division:

Oahu: . . . . . 586-9161 (Workers' Compensation)
586-9188 (Temporary Disability Insurance and Prepaid Health Care)
Hilo: 974-6464
Kona: 322-4808
Maui: 243-5322
Kauai: 274-3351

This notice provides general background information on labor laws administered and enforced by DLIR's Disability Compensation Division and is not intended to serve as a substitute for legal counsel. For specific legal advice on individual situations, please consult an attorney.

Nelson B. Befitel, Director
Department of Labor and Industrial Relations

*You may satisfy Hawaii Labor Laws' posting requirements by posting our official labor law poster.
Click this link for more information: http://hawaii.gov/labor/poster_2006.shtml

NOTICE TO EMPLOYEES

WORKERS' COMPENSATION

Employer Name: **Sample Corporation**

The above named employer, an employer within the meaning of the Workers' Compensation Law of the State of **Iowa**, hereby gives notice to employees that the employer has secured the payment of Compensation to its employees and their dependents in accordance with the provision of said law, by insuring with:

Insurance Company: **Global Casualty Company**
888 Asylum Street
Hartford, CT 06543
800-555-1212

Policy Effective Dates: **10/1/2007 to 10/1/2008**

Policy Number: **WCAI_571971**

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Claims Administered By: **Gallagher Bassett Services**
Two Pierce Place
Itasca, IL 60143-3141
Telephone 630.773.3800

Date Posted: _____

TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE UPON YOUR PREMISES.

NOTICE

REGARDING WORKERS' COMPENSATION INSURANCE

ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPLIED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKERS' COMPENSATION LAW.

Sample Corporation
Employer

Date

By Official Signature
Ronald T. Waxmen
Employer's Authorized Agent

An employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer; by the surety, Global Casualty Company

or upon application, by the Industrial Commission in Boise, Idaho.

ICREV 11/94.EMP

PARA EL PATRON: ESTE AVISO DEBE SER PUESTO EN UN LUGAR CONSPICUO EN SU SITIO DE NEGOCIO.

AVISO

RESPECTO A EL SEGURO DE COMPENSACIÓN PARA TRABAJADORES

TODOS LOS TRABAJADORES EMPLEADOS POR EL SUSCRITO SON, POR LA PRESENTE, NOTIFICADOS QUE EL PATRÓN HA CUMPLIDO CON LA LEY CON RESPECTO A ASEGURAR EL PAGO DE COMPENSACIÓN A LOS EMPLEADOS Y SUS DEPENDIENTES, DE ACUERDO CON LAS PROVISIONES DE LA LEY DE COMPENSACIÓN PARA TRABAJADORES.

Sample Corporation
Patrón

Fecha

Official Signature
Por Ronald T. Waxmen
Agente Autorizado del Patrón

Un empleado que recibe un daño en un accidente tiene que notificar immediatamente a su mayordomo o mayordoma, superintendente o a la persona suscrita, quien proveera atención médica.

Reclamación para compensación tiene que ser hecha por escrito y entregada al patrón. Formas explicando el daño y reclamando compensación serán proveidas por el patrón; por el fiador, Global Casualty Company

o con solicitud, por La Comisión Industrial en Boise, Idaho.

ICREV05/95.EMP2

WORKERS' COMPENSATION

is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU SUFFER FROM A WORK-RELATED INJURY OR ILLNESS, YOU SHOULD TAKE THE FOLLOWING STEPS:

1. **GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. The employee may choose two physicians, surgeons, or hospitals. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits.

2. **NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.

3. **LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Industrial Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Industrial Commission or go to the Web site.

   If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

   It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

4. **KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

   Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Industrial Commission's Web site or call any office:

Toll-free: 866/352-3033 Chicago: 312/814-6611 Peoria: 309/671-3019 Springfield: 217/785-7087
Web site: www.state.il.us/agency/iic Collinsville: 618/346-3450 Rockford: 815/987-7292 TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims	Gallagher Bassett Services		
Business address	Two Pierce Place Itasca, IL 60143-3141		
Business phone	630.773.3800		
Effective date	10/1/2007	Termination date	10/1/2008
Policy number	WCAI_571971	Employer's FEIN	987654321

ICPN 1/04 Printed by the authority of the State of Illinois.

COMPENSACION A LOS TRABAJADORES

es un sistema de beneficios que por ley se provee a la mayoría de empleados que se han enfermado o accidentado en el trabajo. Los beneficios son pagados por lesiones que son causadas en parte o completamente por el trabajo del empleado. Esto puede incluir el agravante o una condicion pre-existente, lesiones causadas por uso repetitivo de una parte del cuerpo, ataques cardiacos, o cualquier otro problema físico causado por el trabajo. Los beneficios son pagados sin importar la causa.

SI USTED SUFRE DE UNA LESION O ENFERMEDAD RELACIONADA AL TRABAJO, USTED DEBE TOMAR LAS SIGUIENTES MEDIDAS:

1. **OBTENGA AYUDA MEDICA.** Por ley, su empleador debe pagar por todos los servicios medicos necesarios que se requieran para aliviar los síntomas de lesión o enfermedad. El empleado puede escoger dos doctores, cirujanos u Hospitales. Si es necesario, el empleador debe pagar por rehabilitación física, mental o profesional dentro de los límites establecidos.

2. **NOTIFIQUE A SU EMPLEADOR.** Usted debe notificar a su empleador del accidente o enfermedad dentro de 45 días, ya sea por escrito o verbalmente. Para evitar posibles demoras, es recomendable que la nota incluya su nombre, direccion, numero telefónico, número de Seguro Social, y una breve descripción de la lesión o enfermedad.

3. **CONOZCA SUS DERECHOS.** Su empleador por ley debe reportar accidentes que resulten en mas de tres días de ausencia al trabajo, a la Comisión Industrial. Una vez que el accidente es reportado, usted recibirá un manual que explica la ley, beneficios y procedimientos. Si necesita un manual, por favor llame a la Comisión Industrial o visite nuestra red.

   Si usted tiene que faltar al trabajo para recuperarse de la lesión o enfermedad., usted tiene derecho a recibir pagos semanales y atención médica necesaria hasta que este capacitado para regresar a trabajar y que el trabajo este de acuerdo a sus capacidades.

   Es contra la ley que el empleador moleste, despida o se niegue a reemplear o de alguna manera descrimine contra un empleado por ejercitar sus derechos de conformidad con las leyes que rigen el seguro de accidentes de trabajo de enfermedades profesionales. Si usted hace una demanda fraudulenta, podrá ser castigado por la ley.

4. **MANTENGASE DENTRO DEL LIMITE DE TIEMPO.** Usualmente, las quejas deben ser presentadas dentro de los primeros tres años del accidente o incapacidad de una emfermedad profesional, o dentro de dos años del último pago de compensación de trabajo, lo que sea mas reciente. Quejas por neumoconiosis, exposición radiologica, asbestos, o enfermedades similares tienen requerimientos especiales.

   Los empleados accidentados tienen derecho para volver a abrir su caso dentro de 30 meses después que la Comisión haya otorgado una decisión y la incapacidad haya incrementado, pero en casos resueltos por una suma global aprobada por la Comisión no pueden volver a abrirse. Unicamente las decisiones aprobadas por la Comisión son obligatorias.

Para mas información, visite la Red de la Comisión Industrial o llame a nuestras oficinas:

Toll-free:	866/352-3033	Chicago:	312/814-6611	Peoria:	309/671-3019	Springfield:	217/785-7087
Web site:	www.state.il.us/agency/iic	Collinsville:	618/346-3450	Rockford:	815/987-7292	TDD (Sordo):	312/814-2959

LOS EMPLEADORES DEBEN EXHIBIR ESTE AVISO EN UN LUGAR VISIBLE PARA TODOS LOS EMPLEADOS Y LLENAR LA INFORMACIÓN ABAJO REFERENTE A LA COMPAÑIA DE SEGUROS.

Nombre: **Gallagher Bassett Services**

Dirección de la Compañia: **Two Pierce Place**
Itasca, IL 60143-3141

Teléfono de la Compañia: **630.773.3800**

Fecha efectiva: **10/1/2007** Fecha de terminación: **10/1/2008**

Número de Póliza: **WCAI_571971** FEIN del Empleador: **987654321**

ICPN 1/04 Impreso por la autoridad del Estado de Illinois.

WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The worker's compensation insurance carrier or the administrator for

Sample Corporation **is:** **Gallagher Bassett Services**
(name of company) **(name of insurance carrier or administrator)**

Gallagher Bassett Services
(name of carrier/administrator)

Two Pierce Place
(mailing address)

Itasca, IL 60143-3141
(city, state, zip)

630.773.3800
(telephone number)

Claim Call Center
(contact person)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

NOTICIA DE COMPENSACION PARA TRABAJADORES

A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.

Cualquier empleado que sea lesionado mientras esté trabajando debe reportar el accidente laboral inmediatamente a su supervisor, empleador o representante designado.

La compañía de seguro de compensación del trabajador o el administrador de la compañía

Sample Corporation **es:**

(nombre de la compañía)

Gallagher Bassett Services

(nombre de la compañía de seguro/administrador)

Two Pierce Place

(dirección)

Itasca, IL 60143-3141

(ciudad, estado, código postal)

630.773.3800

(número de teléfono)

Claim Call Center

(persona de contacto)

Para más información acerca de sus derechos o los procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

This notice must be posted and maintained by the employer in one or more conspicuous places.

★ NOTICE ★

Your employer is subject to the Kansas Workers Compensation law which provides compensation for job-related injuries.

1-800-332-0353

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

Notify your employer immediately. **Your claim may be denied if you fail to tell your employer within 10 DAYS of the injury**. For just cause you may have 75 days to tell the employer of your injury. Thereafter you **must** file a written claim within 200 days of the accident or last date benefits are paid. Submission of Employer's Report of Accident does not constitute a written claim.

MEDICAL BENEFITS

An employer is required to furnish all necessary medical treatment and has the right to designate the treating physician. If the employee seeks treatment from a doctor not authorized by the employer, the employer or its insurance carrier is only liable up to $500.00.

WEEKLY BENEFITS

Benefits are paid by the employer's insurance carrier or self-insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3% of his average weekly wage up to a maximum of 75% of the state's average weekly wage.

These benefits are subject to legislative changes and for the latest information on benefit levels, please contact the Division at the address and phone number below. If the injury results in permanent disability, the Kansas compensation law provides for additional benefits.

Helpful Information – Ombudsman

Contact the **Ombudsman/Claims Advisory Section** at the Division of Workers Compensation immediately if you do not receive compensation in a timely manner. The Division has full-time personnel who specialize in aiding injured workers with claim problems. They can give information on what benefits an injured worker is entitled to receive. Such problems as benefits not being paid on time, unpaid medical bills, questions in regard to proper settlement amounts, etc., should be brought to the attention of the **Ombudsman/Claims Advisory Section**. Injured workers may use our toll free telephone number **1-800-332-0353**.

WHERE TO GET HELP WITH YOUR CLAIM:

Current claims are being administered by Gallagher Bassett Services

The claims office is located at Two Pierce Place, Itasca, IL 60143-3141 telephone 630.773.3800

INFORMACIÓN SOBRE COMPENSACIÓN DE TRABAJADORES

La ley exige que cuando un trabajador llega a sufrir un accidente, una herida, o una enfermedad a causa de su empleo, el empleador debe proporcionarle al trabajador incapacitado tratamiento médico y otros beneficios sin ningún costo al trabajador. El trabajador incapacitado tiene derecho a recibir un sueldo reducido, mientras se restablece. La ley tambien protege los derechos del trabajador incapacitado en otras maneras, por ejemplo: se prohibe el desempleo de un trabajador solo por haber reclamado los beneficios de la compensación de trabajadores. Reporte cada accidente o lastimadura industrial inmediatamente al patrón, o al empleador. Su reclamo puede ser negado si usted no notifica (avisa) a su empleador (patrón) dentro de 10 días del accidente o lastimadura. Por buena causa usted puede tener 75 días para avisarle a su empleador (patrón) de su accidente o lastimadura. De allí en adelante, usted debe entregar un aviso por escrito dentro de 200 días del accidente o último día que recibío tratamiento medico, o que recibío beneficios. Un reporte de accidente no constituta un aviso por escrito. Para mas información acerca de los beneficios o para recibir asistencia con un reclamo, llame al teléfono 1-800-332-0353 (gratis) o al 785-296-2996.

KANSAS
DEPARTMENT OF LABOR

Division of Workers Compensation
800 S.W. Jackson Street, Suite 600, Topeka, KS 66612-1227
Phone: 785-296-2996
Web site: www.dol.ks.gov • E-mail: workerscomp@dol.ks.gov

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at 1-800-766-3777.

K-WC 40 (Rev. 11-06)

COMMONWEALTH OF KENTUCKY

WORKERS COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers' Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: **Sample Corporation**	
Address: **432 Park Ave. New York, NY 10020**	
Workers Compensation Carrier (or third party administrator): **Gallagher Bassett Services**	
Policy #: **WCAI_571971**	Effective Dates: **10/1/2007 to 10/1/2008**
Address: **Two Pierce Place Itasca, IL 60143-3141**	
Telephone: **630.773.3800**	
Contact Person: **Claim Call Center**	

EMPLOYEES: If INJURED - NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ IS NOT ☒ participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is **United Health Care**.

Its represntative is **Victor Hugo**, phone number **(414) 231-4410**.

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers' Compensation Act after seven (7) days of disability. A CLAIM MUST BE filed with the Office of Workers Claims WITHIN TWO YEARS of the date of injury, or last payment of temporary disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers' compensation rights are not promptly answered call The Kentucky Office of Workers' Claims at 1-800-554-8601 to speak to an Ombudsman or Workers' Compensation Specialist.

EMPLOYER SUPERVISORS - NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT A TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

workers' compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

1 the disease manifests itself.

2 the employee is disabled as a result of the disease.

3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

1 the date of death.

2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

Global Casualty Company
888 Asylum Street
Hartford, CT 06543
800-555-1212

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

Ronald T. Waxmen, HR Director
1010 N Captain Way
Building 1A-393
Houston, TX 32001
Telephone: 253.630.1111
Email: rep@repemail.com

Employer

Sample Corporation
432 Park Ave.
New York, NY 10020
253.630.1111

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised 5/2003

LOUISIANA WORKS™
DEPARTMENT OF LABOR

www.LAWORKS.net

workers' compensation

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Revised 5/2003

LOUISIANA WORKS™
DEPARTMENT OF LABOR

www.LAWORKS.net

NOTICE TO EMPLOYEES **NOTICE TO EMPLOYEES**

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

600 Washington Street, Boston, Massachusetts 02111
617-727-4900 - http://www.mass.gov/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above-mentioned chapter by insuring with:

Global Casualty Company	
NAME OF INSURANCE COMPANY	
888 Asylum Street, Hartford, CT 06543	
ADDRESS OF INSURANCE COMPANY	
WCAI_571971	**10/1/2007 to 10/1/2008**
POLICY NUMBER	EFFECTIVE DATES
Marsh USA	**1066 Avenue of the Americas, PO Box 1234 New York, NY 10036** **800-123-4567**
NAME OF INSURANCE AGENT	ADDRESS PHONE #
Sample Corporation	**432 Park Ave. New York, NY 10020**
EMPLOYER	ADDRESS
Ronald T. Waxmen	
EMPLOYER'S WORKERS' COMPENSATION OFFICER (IF ANY)	DATE

MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

Mass General	**1 University Ave. Boston, MA 02110**
NAME OF HOSPITAL	ADDRESS

TO BE POSTED BY EMPLOYER

LABELS FOR MARYLAND WORKERS' COMPENSATION POSTER

EMPLOYER:
Sample Corporation
432 Park Ave.
New York, NY 10020
TELEPHONE:
EMPLOYER'S FEDERAL ID NUMBER (FEIN): 987654321

INSURANCE COMPANY:
Global Casualty Company
INSURANCE COMPANY TELEPHONE: 800-555-1212

WORKERS' COMPENSATION

WORKERS' COMPENSATION BOARD REGIONAL OFFICES

AUGUSTA
24 Stone Street
Augusta, ME 04330
207-287-2308
1-800-400-6854

LEWISTON
36 Mollison Way
Lewiston, ME 04240-5811
207-753-7700
1-800-400-6857

BANGOR
106 Hogan Road
Bangor, ME 04401
207-941-4550
1-800-400-6856

PORTLAND
62 Elm Street
Portland, ME 04101
207-822-0840
1-800-400-6858

CARIBOU
43 Hatch Drive, Suite 110
Caribou, ME 04736-2347
207-498-6428
1-800-400-6855

Visit our website at:
www.maine.gov/wcb
Statewide TTY: 1-877-832-5525

Notice to Employees:

State law requires your employer to provide workers' compensation insurance for its employees. Workers' compensation insurance provides benefits to employees who are injured at work.

If you are injured at work, NOTIFY YOUR EMPLOYER AT ONCE. You may lose your right to receive benefits unless your employer is notified within 90 days of your injury. Your claim is also subject to a two year statute of limitations. Worker advocates are available at the Workers' Compensation Board to help injured workers.

If you have any questions about your rights, please contact one of the regional offices.

A l'intention desEmployes:

D'après les lois de l'Etat du Maine, votre employeur est tenu de souscrire à une assurance indemnisant ses employés victimes d'un accident du travail.

Si vous êtes victime d'un accident du travail, PREVENEZ VOTRE EMPLOYEUR IMMEDIATEMENT. Passé un délai de 90 jours, vous risquez de perdre vos droits à l'indemnisation. Au-delà de deux ans, votre déclaration n'est plus recevable. Pour aider les victimes d'un accident du travail, le Workers' Compensation Board met des conseillers juridiques à leur disposition.

Si vous n'êtes pas sûr de vos droits, veuillez contacter l'un des bureaux régionaux.

Aviso a los Trabajadores:

La ley del estado de Maine requiere que su empresario proporcione el seguro de compensaciones para el trabajador a todos los trabajadores. El seguro de compensaciones para el trabajador proporciona beneficios a los trabajadores accidentados en el trabajo.

En caso de sufrir accidente o daño laboral, NOTIFÍQUELO INMEDIATAMENTE A SU EMPRESARIO. Podría perder el derecho a recibir compensación a menos que su empresario sea notificado de este accidente o daño en el plazo de 90 días. Así mismo esta reclamación debe hacer referencia a un accidente o daño que no haya ocurrido hace más de dos años. Los defensores del trabajador están disponibles para proporcionar ayuda a los trabajadores accidentados en el Consejo de Administración de Compensaciones para el Trabajador (Workers' Compensation Board).

En caso de tener cualquier pregunta sobre sus derechos, favor de dirigirse a una de las oficinas regionales de compensaciones para el trabajador.

ENGLISH
Interpreters Available
When calling for assistance, please say the name of your language in English and an interpreter will be called for you. Please stay on the line.

SPANISH
Tenemos intérpretes a su disposición
Si necesita que le atiendan en español por favor diga "Spanish" y le conectaremos con un intérprete. Por favor manténgase en la línea.

PORTUGUESE
Temos intérpretes à sua disposição
Se precisar de atendimento em Português, por favor diga "Portuguese" e um intérprete será prontamente chamado. Por favor, aguarde na linha.

ITALIAN
Abbiamo intèrpreti disponibili
Se avete bisogno di assistenza in Italiano, Vi preghiamo di dire "Italian" e un intèrprete sarà messo a Vostra disposizione. Vi preghiamo di rimanere in linea.

FRENCH
Des interprètes sont à votre disposition
Lorsque vous appelez pour demander de l'aide, prononcez le mot "French" et nous mettrons un interprète à votre disposition. Prière de rester en ligne.

POLISH
Tłumacze dostępni na życzenie.
Aby uzyskać pomoc tłumacze, proszę powiedzieć po angielsku "Polish" i czekać na linii.

RUSSIAN
"К вашим услугам имеются переводчики"
"Когда Вы обращаетесь за помощью по телефону, пожалуйста скажите, что Вы говорите по-русски (произнесите "РАШН"), и мы обеспечим Вас переводчиком. После этого, пожалуйста, оставайтесь на линии."

CHINESE
提供口譯服務
打電話請求幫助時，請用英語說"挾音呢斯"(CHINESE)— 我們將爲您提供口譯人員。請不要挂斷電話。

JAPANESE
通訳サービスをご利用いただけます
通訳を必要とされる場合は「ジャパニーズ」とおっしゃり、通訳がでるまでそのままでお待ちください。

KOREAN
한국어 통역을 이용하실 수 있습니다.
도움이 필요하여 전화를 거실 때 영어로 코리언(KOREAN)이라고 말씀하시면 통 역자를 연결해 드릴 것입니다. 전화를 끊지 마시고 기다리십시오.

VIETNAMESE
"Có Thông Dịch Viên"
"Khi gọi điện thoại để được giúp đỡ, xin quý vị hãy nói "VIETNAMESE" để chúng tôi cho thông dịch viên giúp quý vị. Xin quý vị chờ trên đường dây.

ARABIC
مترجمون شفهيون متيسرون لخدمتكم
عند إتصالكم للمساعدة أو لطلب خدمة معينة نرجو منكم أن تذكروا (أ-ز-ب-ك) ونحن سنقدّم لكم مترجما شفهيا . ابقوا على الخط من فضلكم.

PERSIAN
افراد مترجم در دسترس مي باشند.
را كه بدان صحبت مي كنيد به انگليسي ذكر كنيد تا راجع به امري به ما تلفن مي كنيد، لطفاً نام زباني قطع نكنيد. هنگاميكه براي درخواست كمک يا شما تماس گرفته شود. لطفاً روي خط منتظر بمانيد.
با يک مترجم براي

SOMALI
Turjunaanno waa la helayaa
Marka aad caawinaad inoogu soo yeeraneysid, fadhlan luqaddaada af Ingiriisi inoogu sheeg turjubaan ayaa lguugu yeeri doonaaye. Taleefoonkana ha dhigin.

To the employer: This notice must be posted in a conspicuous place upon your premises accessible to employees. 39-A MRSA §406. The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services or activities.
This poster is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: (888) 801-9087 or TTY (877) 832-5525.

WCB-90 (1/06)

NOTICE TO EMPLOYEES

WORKERS' COMPENSATION

Employer Name: **Sample Corporation**

The above named employer, an employer within the meaning of the Workers' Compensation Law of the State of **Michigan**, hereby gives notice to employees that the employer has secured the payment of Compensation to its employees and their dependents in accordance with the provision of said law, by insuring with:

Insurance Company: **Global Casualty Company**
888 Asylum Street
Hartford, CT 06543
800-555-1212

Policy Effective Dates: **10/1/2007 to 10/1/2008**

Policy Number: **WCAI_571971**

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Claims Administered By: **Gallagher Bassett Services**
Two Pierce Place
Itasca, IL 60143-3141
Telephone 630.773.3800

Date Posted: _____

Minnesota Workers' Compensation
Employee rights and responsibilities

This notice is required by law to be posted in a conspicuous location wherever the employer is engaged in business.

If you are injured:

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not timely report the injury to your employer. The time limit may be as short as 14 days, although under certain circumstances, it may be longer.
- Provide your employer with as much information as possible about your injury so that a proper injury report can be filed.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you if you are covered by a CMCO.
- Cooperate with all requests for information concerning your workers' compensation claim. Please note: the law provides that the workers' compensation insurer can obtain medical information specific to your work injury without your authorization, provided you are sent written notification of this request at the time the request is made.
- Get written confirmation from your doctor on any authorization to be off work.

What does workers' compensation pay for?

- Medical care for your work injury, as long as it is reasonable and necessary
- Wage-loss benefits for part of your lost income (there is a three-calendar-day waiting period before these benefits start)
- Compensation for permanent damage to or loss of function of a body part
- Benefits to your spouse and/or dependents if you die as a result of a work injury
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury

What the insurance company must do:

- Investigate your claim promptly.
- Within 14 days of when the claimed injury occurred or when your employer became aware of it, either begin payment of benefits due or file a denial of liability, explaining why benefits are being denied.

Insurer name:	**Global Casualty Company**	**Phone number:**	**800-555-1212**

If the insurer *accepts* your claim for wage-loss benefits and you have been disabled for more than three calendar-days:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the date your employer knows about your work injury and lost wages. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.

If the insurer *denies* your claim for wage-loss benefits:

- The insurer will send you a copy of the *Notice of Insurer's Primary Liability Determination* form stating it is denying primary liability for your claim. The form must clearly explain the facts and reasons why the insurer believes your injury or illness did not result from your work.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Your employer's insurance company can answer most questions about your claim.
- If you are not satisfied with the response you receive from the insurer and still disagree with the denial, you should contact the Department of Labor and Industry at one of the numbers listed below to discuss your options.

Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Any theft of more than $500 is a felony.

Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3.

A suspected fraud can be reported by anyone. If you have reason to suspect someone is committing workers' compensation fraud, call 1-888-FRAUD MN (1-888-372-8366). All suspected violations will be investigated.

If you have questions or need more help, call the Minnesota Department of Labor and Industry:

Workers' Compensation Hotline
1-800-DIAL-DLI
(1-800-342-5354)
8 a.m. to 4:30 p.m.,
Monday-Friday

Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road N.
St. Paul, MN 55155
Phone: (651) 284-5032
TDD: (651) 297-4198

Department of Labor and Industry
Workers' Compensation Division
5 N. Third Ave. W., Suite 400
Duluth, MN 55802
Phone: (218) 733-7810
Toll-free: 1-800-365-4584

Your claim will be answered by experienced workers' compensation specialists who will provide **instant, accurate information and assistance.** Additional workers' compensation information is available on the department Web site at *www.doli.state.mn.us*.

August 2003

This document can be made available in alternative formats, such as Braille or audiotape, by calling (651) 284-5042 or (651) 297-4198/TDD.

Seguro de compensación a trabajadores por accidentes en el trabajo de Minnesota. Derechos y responsabilidades de los empleados

Minnesota Workers' Compensation Employee's rights and responsibilities (Spanish)

La ley requiere que este aviso se coloque en un lugar visible dondequiera que una empresa lleve a cabo actividades comerciales

Si usted se lesiona:

- Infórmele a su supervisor cualquier lesión que sufra tan pronto como sea posible, independientemente de cuán leve parezca ser. Es posible que pierda su derecho a recibir beneficios del seguro de compensación a trabajadores por accidentes en el trabajo si no le informa oportunamente a su empleador que sufrió una lesión. Es posible que el plazo límite para informar sea sólo 14 días, aunque puede ser más largo bajo ciertas circunstancias.
- Proporciónele a su empleador la mayor cantidad de información que sea posible acerca de su lesión, de manera que pueda hacerse el informe de lesión correspondiente.
- Obtenga cualquier tratamiento médico que sea necesario tan pronto como sea posible. Si no tiene cobertura bajo una organización certificada de atención administrada (certified managed care organization - CMCO), puede acudir a cualquier médico de su elección para recibir el tratamiento. Su empleador debe notificarle si está cubierto bajo una organización CMCO.
- Coopere con todas las solicitudes de información acerca de su reclamación de compensación a trabajadores. Tome nota: la ley estipula que la compañía de seguro de compensación a trabajadores podrá obtener información médica relacionada específicamente con su lesión en el trabajo sin la autorización suya, siempre y cuando le envíe un aviso por escrito de dicha solicitud al momento de hacerla.
- Obtenga confirmación por escrito de su médico de cualquier autorización para ausentarse del trabajo.

¿Qué le paga su seguro de compensación?

- Atención médica por su lesión en el trabajo, siempre y cuando la misma sea razonable y necesaria.
- Beneficios parciales por pérdida de ingresos. (Hay un período de espera de tres días civiles antes de que comiencen estos beneficios.)
- Compensación por daños permanentes o por la pérdida del funcionamiento de una parte del cuerpo.
- Beneficios a su cónyuge y/o sus dependientes si usted fallece como resultado de una lesión en el trabajo.
- Servicios de rehabilitación vocacional si, a causa de una lesión en el trabajo, usted no puede regresar al trabajo que tenía o a la empresa para la que trabajaba antes de sufrir dicha lesión.

Lo que debe hacer la compañía de seguro:

- Investigar su reclamación de manera puntual.
- Comenzar a pagarle los beneficios, o presentar un rechazo de responsabilidad que explique por qué le están negando la solicitud de beneficios, dentro de un plazo de 14 días de usted haber sufrido la lesión por la cual hizo la reclamación o de que su empleador se haya enterado de la misma.

Nombre del asegurador:	**Global Casualty Company**	Número telefónico:	**800-555-1212**

Si el asegurador *acepta* su reclamación de beneficios por pérdida de ingresos y usted ha estado incapacitado por más de tres días civiles:

- El asegurador le enviará una copia del formulario de *Aviso de Determinación de Responsabilidad Principal del Asegurador* (Notice of Insurer's Primary Liability Determination) indicando que aceptó su reclamación.
- El asegurador deberá comenzar a pagarle los beneficios por pérdida de ingresos dentro de un plazo de 14 días desde que su empleador se haya enterado de su lesión en el trabajo y de su pérdida de ingresos. El asegurador deberá pagar los beneficios de manera puntual. Los beneficios por pérdida de ingresos se pagan a los mismos intervalos de tiempo que sus cheques de nómina.

Si el asegurador *rechaza* su reclamación de beneficios por pérdida de ingresos:

- El asegurador le enviará una copia del formulario de *Aviso de Determinación de Responsabilidad Principal del Asegurador* (Notice of Insurer's Primary Liability Determination) indicando que está rechazando la responsabilidad principal por su reclamación. El formulario debe explicar claramente los hechos y los motivos por los cuales el asegurador cree que su lesión o enfermedad no resultó de su trabajo.
- Si usted no está de acuerdo con el rechazo, debe hablar con el tasador de reclamaciones de seguro que esté encargado de su reclamación. La compañía de seguros de su empleador podrá responder a la mayoría de sus preguntas acerca de su reclamación.
- Si no está satisfecho con la respuesta que reciba del empleador y aún no está de acuerdo con el rechazo, debe comunicarse con el Departamento del Trabajo y la Industria llamando a uno de los números que se indican a continuación para hablar acerca de sus opciones.

Fraude

Cobrar beneficios de compensación a trabajadores por accidentes en el trabajo si usted no tiene derecho a los mismos constituye robo. Cualquier robo de más de $500 constituye un delito grave.

Cualquier persona que, con la intención de defraudar, reciba beneficios de compensación a trabajadores por accidentes en el trabajo a los que la misma no tiene derecho, haciendo declaraciones falsas o inexactas, u ocultado cualquier hecho substancial, es culpable de robo y recibirá una sentencia de conformidad con la sección 609.52, subdivisión 3.

Cualquier persona puede informar una sospecha de fraude. Si usted tiene algún motivo de sospechar que alguien está cometiendo fraude de compensación a trabajadores por accidentes en el trabajo, llame al 1-888-FRAUD MN (1-888-372-8366). Se investigará toda sospecha de infracción.

Si tiene preguntas o necesita más ayuda, llame al Departamento del Trabajo y la Industria de Minnesota:

Línea directa de compensación a trabajadores

1-800-DIAL-DLI
(1-800-342-5354)
de 8 a.m. a 4:30 p.m.,
de lunes a viernes

Departamento del Trabajo y la Industria
División de Compensación a Trabajadores por Accidentes en el Trabajo
443 Lafayette Road N.
St. Paul, MN 55155
Teléfono: (651) 284-5042
TDD: (651) 297-4198

Departamento del Trabajo y la Industria
División de Compensación a Trabajadores por Accidentes en el Trabajo
5 N. Third Ave. W., Suite 400
Duluth, MN 55802
Teléfono: (218) 723-4670
Línea gratuita: 1-800-365-4584

Especialistas en compensación a trabajadores con experiencia responderán a su reclamación y le proveerán **información y asistencia instantáneas y precisas.** Hay información adicional acerca de la compensación a trabajadores por accidentes en el trabajo disponible en el sitio de Internet del departamento en *www.doli.state.mn.us.*

Enero del 2003

Este documento está disponible en formatos alternativos como Braille o audiocinta llamando al (651) 284-5042 o al (651) 297-4198/TDD.

Missouri Department of Labor and Industrial Relations

DIVISION OF WORKERS' COMPENSATION

This employer is operating under and subject to the provisions of the Missouri Workers' Compensation Law.

If A Work Injury Occurs . . .

Missouri law guarantees certain benefits to employees who are injured or become ill because of their jobs. An injury occurs out of and in the course of employment. An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. An injury by occupational disease is compensable only if the occupational exposure was the prevailing factor in causing both the resulting medical condition and disability. Check with your supervisor if you have any questions.

Workers' Compensation Benefits Include . . .

In addition to all other compensation paid to the employee under §287.140 RSMo, the employee is entitled to receive:

★ **Medical Care**. The employer shall provide medical care as may reasonably be required after the injury or disability to cure and relieve the employee from the effects of the injury. Medical treatment is without a deductible to the employee or dollar limit. Costs are paid directly by your employer's insurance company, so you should not receive a bill. If you do receive a bill, give it to the employer's designated representative or contact the insurer listed below.

Your employer will arrange for medical treatment and select a doctor to care for your workers' compensation injury. If you want to change doctors, you must get prior authorization from the employer.

If you go to another doctor without prior authorization, it is at your expense.

★ **Payment for Lost Wages**. If you are unable to return to any form of employment due to the injury or illness, you should receive temporary total disability (TTD) benefits that are tax-free, until the treating doctor says you are able to return to work. Payments are two-thirds of your average weekly wage, up to a maximum rate set by state law. Payments are not made for the first three days or less that your employer is open for business, unless you are unable to work more than 14 calendar days. If you do not receive a check, contact the insurer listed below. An employee is disqualified from receiving TTD during any period of time that the employee applies and receives unemployment compensation.

★ **Permanent Disability Benefits**. If the injury or illness results in a permanent disability you may be entitled to receive either permanent partial or permanent total disability benefits.

★ **Death Benefits**. If the injury results in death, benefits will be paid to surviving dependents.

In The Event Of A Work Injury . . .

Employer Must:

1. Be sure first aid is given.
2. See that the injured employee is directed to a doctor or hospital, if necessary.

Employee Must:

1. Report the injury IMMEDIATELY to your supervisor or **Ronald T. Waxmen** *(Employer's Designated Representative)* at **253.630.1111** *(Phone Number)*.

   Employees who fail to notify the employer of a work injury within thirty days may jeopardize their ability to receive workers' compensation benefits.
2. If you have questions about Workers' Compensation, your employer will supply you with additional information; or you may contact an Information Specialist at the Division of Workers' Compensation 1-800-775-COMP.

Insurance Company, Third Party Administrator, Service Company, or Designated Individual If Self-Insured

Name **Gallagher Bassett Services**

Address **Two Pierce Place**
Itasca, IL 60143-3141

Phone Number **630.773.3800**

(Please do not insert the Division of Workers' Compensation or its toll-free number in this section)

If Noncompliance Occurs . . .

Contact 1-800-592-6003 if you believe your employer does not:

1. Insure his/her employees with workers' compensation insurance. (Coverage is required for employers who have five or more employees, one or more if in the construction industry.)
2. Report employee injuries to the Division of Workers' Compensation.
3. Post workers' compensation notice.

★ An employer who fails to insure its liability shall be guilty of a class A misdemeanor punishable by up to one year in jail and penalty of "up to three times" the annual premium the employer would have paid, or "up to $50,000, whichever amount is greater."

If Fraud Occurs . . .

Contact 1-800-592-6003 if you suspect fraudulent action by one of the following:

1. An employee, employer, insurer, physician, attorney or others involved in making a false statement in an attempt to obtain or deny a benefit as it relates to workers compensation. The false statement must be of a material fact.
2. Misrepresentation of job classification made by an employer or an insurer.

★ Fraud is unlawful and subject to criminal prosecution by the state of Missouri.

If you have questions or need more information about Workers' Compensation benefits, contact an Information Specialist at:

Missouri Division of Workers' Compensation
3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058

www.dolir.mo.gov/wc

1-800-775-COMP* • TDD 1-800-735-2966

**This toll-free number is provided for employee's questions only. Section 287.126 RSMo. Other persons with questions may call 888-837-6069 for information and assistance.*

Workplace Safety Contact

The Missouri Division of Labor Standards offers free safety services to Missouri employers through its Missouri Workers' Safety Program (MWSP). MWSP's main goals are to help employers reduce occupational injuries and control workers' compensation costs. The Division also certifies the safety engineering and management program that is provided to employers, upon request, by their insurance carriers.

★ Employers may contact MWSP at 573-751-3403, e-mail mwsp@dolir.mo.gov for information about workplace safety or for a registry of safety consultants and safety engineers who are certified by the Division.

★ Employees are urged to direct safety related questions to their employer's designated safety person.

The Division of Workers' Compensation does not discriminate against individuals with disabilities as mandated by P.L. 101-336, The Americans With Disabilities Act. Alternative format available upon request.

This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 573-751-4231.
This poster must be displayed in its original size 11 x 17.

WC-106 (07-06) AI

Departamento de Labor y Relaciones Industriales de Missouri

DIVISIÓN DE COMPENSACIÓN PARA TRABAJADORES

Este empleo está operando bajo y sujetado a las provisiones de las leyes de 'Compensación para Trabajadores de Missouri'.

Si se lastíma en su trabajo . . .

La Ley de Missouri garantiza ciertos beneficios a los empleados que se lastiman o una enfermedad causada en los trabajos. Una lastimadura que ocurra fuera de o en el curso de trabajo. Una lastimadura por accidente es compensable solamente si el accidente fué un factor prevaleciente que causó las dos, el resultado de condición médica y la incapacidad. Una lastimadura que resulten por exponerse a condiciones o substancias perjudiciales de salud (occupational disease), es compensable solamente si al exponerse a éstas condiciones fué un factor prevaleciente que causó las dos, el resultado de condición médica y la incapacidad. Pregúntele a su supervisor si tiene algunas preguntas.

Beneficios de compensación para trabajadores incluyen . . .

En adición de otras compensaciones pagadas al empleado dentro de 287.140 RsMo.el empleado tiene derecho de recibír:

★ **Tratamiento Médico**. El empleo debe de proveér atención médica razonablemente requerida después de la lastimadura o incapacidad para curar y aliviar al empleado de los efectos de la lastimadura. El tratamiento médico es sin deducír dinero del empleado o límite de dinero. Los costos son pagados directamente por la compañía de seguros de su trabajo, usted no deberá recibír la cuenta. Si usted recibe la cuenta, se la puede dar a un representante designado en su empleo, o póngase en contacto con la seguranza que está alistada más adelante.

Su empleo debe de hacer los arreglos para su tratamiento médico y seleccionar al médico que lo va atender para su lastimadura de compensación de trabajadores. Si usted quiere cambíar de médico, tiene que tener anteriormente una autorización de su empleo.

Si usted va a ver a otro médico sin tener anteriormente una autorización de su empleo, será por su cuenta.

★ **Pagos de Sueldos Perdidos**. Si usted está inhábil de regresar en cualquier forma a trabajar debido a la lastimadura o enfermedad, usted deberá recibír un pago de incapacidad total temporal (TTD) beneficios sin pagar taxes, hasta que el médico le diga cuando puede regresar a trabajar. Los pagos serán dos terceras partes de su salario semanal, hasta un máximo que está proporcionado y establecído por la ley del estado. No se le pagará por los primeros tres días o menos que el empleo está abierto, a menos que no haya podido trabajar por más de 14 días de acuerdo al calendario. Si usted no recibe su pago, póngase en contacto con la agencia de la aseguranza que está alistada más adelante. Un empleado está descalificado de recibír incapacidad total temporal (TTD) durante el periodo de tiempo en que el empleado solicita y recibe compensación de desempleo.

★ **Beneficios de Desabilidad Permanente**. Si la lastimadura o la enfermedad resulta en una incapacidad permanente usted tiene derecho de recibír ya sea un parcial permanente o un total permanente en beneficios de incapacidad.

★ **Beneficios de Muerte**. Si la lastimadura resulta en muerte, los beneficios serán pagados a sus dependientes.

En el evento de una lastimada en el trabajo . . .

La Compañía Debe de:

1. Asegurarse se administren los primeros auxilios.
2. Ver que el empleado accidentado sea dirijido a un doctor u hospital, si es necesario.

El Empleado Debe de:

1. Reportar el accidente INMEDIATAMENTE a su supervisor o **Ronald T. Waxmen** *(Representante designado en su empleo)*
   al **253.630.1111** *(Número de Teléfono)*.
   Empleados que fallen en notificar a su empleo de la lastimadura en el trabajo dentro de treinta días puede arriesgar la habilidad de recibír beneficios de compensación para trabajadores.
2. Si tiene preguntas sobre Compensación para Trabajadores, su empleo le puede dar información adicional o pedír información por medio de un especialista en la División de Compensación para Trabajadores 1-800-775-COMP.

Proveedor de aseguranza, Administración grupo de demandas (Third Party Administrator), Compañía de servicios, o La persona designada(o) asegurado por sí mismo

Nombre **Gallagher Bassett Services**

Domicilio **Two Pierce Place**
Itasca, IL 60143-3141

Teléfono **630.773.3800**

(Por favor no insertar en ésta sección el teléfono sin costo de para la División de Compensación para Trabajadores.)

Si es que falta de cumplimiento ocurre . . .

Llamar al 1-800-592-6003 si usted creé que su empleo no le:

1. No asegura a sus empleados con seguranza de compensación para trabajadores. (Protección es requerida para los trabajos que tienen cínco o más empleados, uno o más si es en la industria de construcción.)
2. No reporta accidentes de los empleados a la División de Compensación para Trabajadores.
3. No pone los anuncios de compensación para trabajadores.

★ Un empleo que falle de sus obligaciones de asegurar será culpable de la clase A mala conducta, será castigado hasta un año en la prisión y una multa de "arriba de tres veces más" del precio anual que deberían pagar el empleo o "hasta $50,000 cualquiera que sea más grande".

Si fraude ocurre . . .

Llame al 1-800-592-6003 si usted sospecha que algún acto fraudalente ha ocurrido por uno de los siguientes:

1. El empleado, empleo, la seguranza, un doctor, un abogado u otras personas envueltas falsamente llenan una declaración para intentar obtener o negar beneficios relacionados con la compensación de trabajadores. La declaración falsa tiene que ser en realidad esencial.
2. Falsear la clasificación de trabajo hecha por la compañía o seguranza.

★ Fraude es contra la ley y sujeto a cargos criminales prosecusión por el Estado de Missouri.

Si tiene preguntas o necesita más información sobre los beneficios de Compensación para Trabajadores, póngase en contacto con un Especialista de Información a:

Missouri Division of Workers' Compensation
3315 West Truman Blvd., P.O. Box 58
Jefferson City, MO 65102-0058
www.dolir.mo.gov/wc
1-800-775-COMP* • TDD 1-800-735-2966

*Este número está designado sin costo, únicamente para empleados con preguntas, Sectión 287.126 RSMo.
Cualquier persona puede llamar al 888-837-6069 para recibír información y asistencia.

Contacto para la seguridad en el trabajo

La División de Normas de Trabajo para Trabajadores de Missouri le ofrece servicios de seguridad a los empleos de Missouri a travéz del Programa de Seguridad de Trabajadores en Missouri (MWSP). MWSP's las principales metas es de ayudar a los empleos en reducír accidentes relacionados con el trabajo y controlar los costos de la compensación de trabajadores. La División también certifica un programa de seguridad manejada y administradamente suministrada para los empleos, si usted la requiere, por medio de la seguranza.

★ Los empleos pueden ponerse en contacto con MWSP al 573-751-3403, por e-mail a mwsp@dolir.mo.gov para información acerca de la seguridad en el trabajo o para un registro de consultantes que suministran seguridad y son certificados por la División.

★ Los empleados deben de dirigír con urgencia sus preguntas relacionadas a la seguridad con la persona designada de su empleo.

La División de Compensación para Trabajadores no descrimina contra individuos desabilitados en acuerdo con los mandatos de P.L.101-336, The Americans with Disabilities Act. Información alternativa está disponible si lo requiere.

Este cartelón es requerido por la Sectión 287.127 RSMo y está disponible a los empleos y a las seguranzas sin costo alguno solo llamando al 573-751-4231.
Este cartelón tiene que ser desplegado en su tamaño original de 11 x 17 (once por diecisiete pulgadas).

WC-106-3 (07-06) AI

MISSISSIPPI WORKERS' COMPENSATION

NOTICE OF COVERAGE

I. Please take notice that your Employer is in compliance with the requirements of the Mississippi Workers' Compensation Law, and **[select one]** **[**has been approved by the Mississippi Workers' Compensation Commission to act as a self-insurer**]**, or **[**maintains workers' compensation insurance coverage with the following:**]**

Global Casualty Company
(Name of insurance carrier or self-insurance group)
888 Asylum Street
Hartford, CT 06543
800-555-1212
(address & telephone number)

II. Individual workers' compensation claims will be submitted to and processed by:

Gallagher Bassett Services
(Name of third party claims administrator or claims office)
Two Pierce Place
Itasca, IL 60143-3141
630.773.3800
(address & phone number)

III. This workers' compensation coverage is effective for the following period: 10/1/2007 to 10/1/2008.

IV. All job related injuries or illnesses should be reported as soon as possible to your immediate supervisor, or to the person listed below:

Ronald T. Waxmen
(Name of employer contact person)

HR Director
(Title & Department/Division)

V. Please be advised that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under the Mississippi Workers' Compensation Law may be charged with violation of Miss. Code Ann. §71-3-69 (Rev. 2000) and upon conviction be subjected to the penalties therein provided.

WORKERS' COMPENSATION

INSURANCE COVERAGE

EMPLOYEE NOTICE

Sample Corporation
432 Park Ave.
New York, NY 10020
253.630.1111

Date:

Policy Number: WCAI_571971

The above-named employer's workers' compensation insurance coverage is active and in good standing for the period of 10/1/2007 **to** 10/1/2008, provided the employer meets all premium and reporting requirements.

IF YOU ARE INJURED

You should report any on-the-job injury to your supervisor, employer, or insurer as soon as possible. You must report the accident within 30 days. A sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under the Montana Workers' Compensation Act must report an accident to the insurer within 30 days.

Report minor injuries to your employer whether or not you receive medical treatment. After you report the injury, your employer has 6 days to notify their insurer. You must submit a written First Report of Injury within 12 months from the date of the accident. You can submit this form to your employer, insurer, or the Department of Labor and Industry.

All employees sustaining a compensable work related injury or occupational disease, other than those who are exempted by statute (Section 39-71-401, MCA), are covered for medical and wage-loss benefits.

You have the right to choose your initial treating physician.

You may continue to receive treatment from your physician unless you receive written notice of referral to a preferred provider or a managed care organization. After providing you with a referral notice, the insurance carrier is no longer liable for treatment provided by your physician unless authorization is obtained to continue treatment.

For specific information about this policy, call or write your employer's insurance carrier:

Global Casualty Company
888 Asylum Street
Hartford, CT 06543
800-555-1212

For general information about workers' compensation, call or write: Montana Department of Labor and Industry, Employment Relations Division, P.O. Box 8011, Helena, MT 59604-8011, Phone (406) 444-6543.

FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE WORKPLACE WILL RESULT IN A $50 FINE AGAINST THE EMPLOYER!

EMPLOYEE WARNING

LOSS OF WORKERS' COMPENSATION INSURANCE COVERAGE

Sample Corporation
432 Park Ave.
New York, NY 10020
253.630.1111

Date:

Policy Number: **WCAI_571971**

The above named employer's workers' compensation insurance coverage issued by the insurance carrier shown below is pending cancellation. Claims occurring on or after **12/31/2006** will not be covered for medical or wage-loss benefits due an injured worker as the result of an injury incurred while in the employment of the named employer, unless the insurance coverage requirements are met by **12/31/2006**.

Should this cancellation not occur, the employer will be given written authorization from the insurance carrier to remove this sign.

This sign will remain posted over the current "Employee Notice" sign until effective workers' compensation insurance is obtained by this firm.

FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE WORKPLACE WILL RESULT IN A $50.00 FINE AGAINST THE EMPLOYER!

For general information about Workers' Compensation, call or write:

Workers' Compensation Regulation Bureau
Employment Relations Division
Montana Department of Labor and Industry
PO Box 8011
Helena MT 59604-8011
Phone – (406) 444-7737

For specific information about this policy call or write the insurance carrier:

Gallagher Bassett Services
Two Pierce Place
Itasca, IL 60143-3141
Telephone 630.773.3800

ERD-801 (Rev. 1/2004)

EMPLOYEE WARNING

LOSS OF WORKERS' COMPENSATION INSURANCE COVERAGE

Sample Corporation
432 Park Ave.
New York, NY 10020
253.630.1111

Date:
Policy Number: **WCAI_571971**

The above named employer's workers' compensation insurance coverage issued by the insurance carrier shown below is in a cancellation status at the request of the employer or as of a change of ownership. Claims occurring on or after **12/31/2006** will not be covered by this insurer for medical or wage loss benefits that may be required as the result of an injury incurred while in the employment of the named insurer.

Should this cancellation not occur, the employer will be given written authorization from the insurance carrier to remove this sign.

This sign will remain posted over the current "Employee Notice" sign until effective workers' compensation insurance is obtained by this firm.

FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE WORKPLACE WILL RESULT IN A $50.00 FINE AGAINST THE EMPLOYER!

For general information about Workers' Compensation, call or write:

Workers' Compensation Regulation Bureau
Employment Relations Division
Montana Department of Labor and Industry
PO Box 8011
Helena MT 59604-8011
Phone – (406) 444-6532

For specific information about this policy call or write the insurance carrier:

Gallagher Bassett Services
Two Pierce Place
Itasca, IL 60143-3141
Telephone 630.773.3800

ERD-802 (Rev. 1/2004)

Form No. 17 - Revised 5/2007
PS-076

EMPLOYER: THIS MUST BE *PROMINENTLY* POSTED. I.C. RULE 201.

WORKERS' COMPENSATION NOTICE
And Instructions to Employers and Employees

All employees of this business suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier, except specifically excluded executive officers.

— IMPORTANT THINGS TO DO IN CASE OF INJURY OR OCCUPATIONAL DISEASE —

The Employee Should:

1. Immediately give the employer notice in writing of injury or occupational disease. Failure to inform the employer within thirty (30) days after an injury or the development of most occupational diseases, or the refusal to accept medical services provided by the employer, may deprive the employee of the right to compensation.

2. File claim with the Industrial Commission within two (2) years of the accidental injury or two (2) years after the death, disability or disablement caused by an occupational disease. (The Commission's Form 18 may be used to give notice to employer and to file a claim.) In case of fatal injury, claim must be filed by one or more dependents or next of kin of the deceased employee within two years after such death.

3. If no agreement is reached with the employer with regard to payment of compensation for injury or occupational disease, or if a disagreement develops over compensation due, the employee should promptly request the Industrial Commission to hold a hearing to decide the issues. Benefits may be denied if the request is made more than two (2) years after the date of injury or last payment of cash compensation.

The Employer Should:

1. Provide all necessary medical, surgical, hospital and rehabilitation services reasonably required to effect a cure, give relief and lessen the period of the employee's disability. N.C.G.S. §97-25. Keep a record and report to insurance carrier/compensation administrator ALL injuries suffered by its employees on the Commission's Form 19. The employer, or the carrier/administrator on its behalf, must mail a Form 19 report to the Industrial Commission within five (5) days of the occurrence or report of an injury causing more than one day's absence from work or $2,000.00 or more in medical treatment, other than treatment provided at the work place. N.C.G.S. §97-92.

2. Pay compensation in accordance with the provisions of the Workers' Compensation Act for disability. Agreements between employer and employee to pay compensation must be submitted to the Industrial Commission for approval.

Información sobre alivio médico y monetario por lesiones ocurridas en el empleo.

NORTH CAROLINA INDUSTRIAL COMMISSION
4340 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4340
(919) 807-2500

Forma 17 - Revisada 3/2004
PS-076

EMPLEADOR: ESTA INFORMACIÓN DEBE ESTAR *PROMINENTEMENTE* VISIBLE.
REGLA 201 DE LA COMISIÓN INDUSTRIAL

INFORMACIÓN SOBRE COMPENSACIÓN LABORAL
Instrucciones para Empleadores y Empleados

Todo empleado de este negocio que sufre lesiones relacionadas al trabajo puede tener derecho a beneficios de compensación laboral por parte del empleador o el portador de seguro del empleador, exepto oficiales ejecutivos expresamente excluidos.

— INFORMACIÓN IMPORTANTE EN CASO DE UNA LESIÓN O ENFERMEDAD OCUPACIONAL —

El empleado deberá:

1. Notificar inmediatamente por escrito al empleador sobre la lesión o enfermedad ocupacional. El no informar al empleador dentro de los treinta (30) dias después de una lesión o desarrollo de una enfermedad ocupational, o el rehusar servicios médicos provistos por el empleador, pueden privar al empleado del derecho a compensación.
2. Hacer un reclamo a la Comisión Industrial (Industrial Commission) dentro de los dos (2) años de ocurrir el accidente o lesión, o dos (2) años después de la muerte, incapacidad o incapacitación causada por una enfermedad ocupacional. (Forma 18 de la Comisión puede ser utilizada para dar notificación al empleador y hacer el reclamo en la Comisión.) En caso de una lesión fatal, el reclamó deberá ser hecho por uno o más dependientes o herederos del empleado dentro de los dos (2) años después de la muerte del empleado.
3. Si no se llega a un acuerdo con el empleador en relación al pago de compensación por lesión o enfermedad ocupacional, o si hay un desacuerdo en cuanto se debe de la compensación, el empleado lo mas pronto possible debe pedir una audiencia a la Comisión Industrial para que decidan sobre los méritos del caso. Los beneficios pueden ser negados si la petición se hace después de dos (2) años de la fecha de la lesión o de el último pago de compensación.

El empleador debe:

1. Proveer todo servicio de hospital, médico, quirúrgico, y servicios de rehabilitación necesarios para la cura, el alivio y la minimización del período de incapacitación del empleado. N.C.G.S. §97-25. Mantener un archivo y reportar a la compañía de segurado/administrador de compensación TODAS las lesiones ocurridas a sus empleados usando la Forma 19 de la Comisión. El empleador, o el portador de seguro deben enviar por correo la Forma 19 a la Comisión Industrial dentro de los cinco (5) dias de ocurrido el reporte de una lesión que causa la ausencia del empleado por más de un (1) dia o $2,000.00 o más en tratamiento médico, excluyendo tratamientos provistos en el trabajo. N.C.G.S. §97-92.
2. Pagar compensación al empleado de acuerdo con lo provisto en el la Ley de Compensación Laboral para incapacidad. Los acuerdos de pago de compensación entre empleador y empleado deberán ser sometidos a la Comisión Industrial para su apruebo.

Información sobre alivio médico y monetario por lesiones ocurridas en el empleo.

NORTH CAROLINA INDUSTRIAL COMMISSION
4340 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4340
(919) 807-2500

NOTICE TO EMPLOYEES

WORKERS' COMPENSATION

Employer Name: Sample Corporation

The above named employer, an employer within the meaning of the Workers' Compensation Law of the State of Nebraska, hereby gives notice to employees that the employer has secured the payment of Compensation to its employees and their dependents in accordance with the provision of said law, by insuring with:

Insurance Company: Global Casualty Company
888 Asylum Street
Hartford, CT 06543
800-555-1212

Policy Effective Dates: 10/1/2007 to 10/1/2008

Policy Number: WCAI_571971

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Claims Administered By: Gallagher Bassett Services
Two Pierce Place
Itasca, IL 60143-3141
Telephone 630.773.3800

Date Posted: _____

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

TO EMPLOYEES

1 You are required by law (RSA 281-A:19) to report promptly to your employer an occupational injury or disease, even if you deem it to be minor. Form No. 8a WCA, Notice of Accidental Injury or Occupational Disease, may be used for that purpose (RSA 281-A:20,21). After you have completed and made it available to him or her, your employer must acknowledge receipt by signing and giving you a copy.

2 You are entitled to the services of a physician. This physician shall be within a managed care network, if applicable under RSA 281-A:23a.

3 You may not sue your employer as a result of a work-connected injury or disease by reason of your eligibility for benefits under the Workers' Compensation Law.

TO EMPLOYERS

1 You are required to display this poster so that it will be of the greatest possible benefit to your employees (RSA 281-A:4).

2 You are required to file an Employer's First Report of Injury or Occupational Disease, form No. 8 WC, with the Labor Commissioner, copy to the nearest claims office of your insurance carrier, on all occupational injuries or diseases resulting in one visit to a physician, other than a house physician, as soon as possible but no later than five days after the date of knowledge thereof (RSA 281-A:53, I).

3 You are required to report to the Labor Commissioner, copy as in 2 above, any occupational disability, whether total or partial, of four or more days (RSA 281-A:22), on an Employer's Supplemental Report of Injury, form No. 13 WCA, as soon as possible, but no later than ten days after the date of knowledge thereof (RSA 281-A:53,I and II).

4 You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee in accordance with RSA 281-A:23, 25, 26, 28, 29, 31, 32.

5 All employers with 5 or more full time employees shall develop temporary alternative work opportunities for injured employees in accordance with RSA 281-A:23-b. Employers may be obligated to reinstate employees sustaining a compensable injury in accordance with RSA 281-A:25-a.

6 You are required to obtain from the carrier identified below a supply of all required workers' compensation forms. NOTICE – Violation of the various provisions of the Workers' Compensation Law carries civil penalties, court fines, or both.

David M. Wihby
Deputy Labor Commissioner

George N. Copadis
Labor Commissioner

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations of the Labor Commissioner of the State of New Hampshire pursuant to Revised Statutes Annotated, Chapter 281-A, as amended.

Name of Insurance Company
Or self-insurer:

Global Casualty Company
888 Asylum Street
Hartford, CT 06543

Name of Employer:

Sample Corporation
432 Park Ave.
New York, NY 10020
253.630.1111

By **Ronald T. Waxmen**

987654321
Employer Identification No.
(If number unknown, Employer to request from IRS)

This notice must be posted conspicuously in and about the Employer's place or places of business.

Prescribed by Labor Commissioner
State of New Hampshire
WCP-1 (1-99)

ESTADO DE NEW HAMPSHIRE
LEY DE COMPENSACIÓN PARA TRABAJADORES
AVISO DE LA CONFORMIDAD

A LOS EMPLEADOS

1 Cerca le requieren (RSA 281-A:19) divulgar puntualmente a su patrón lesión o una enfermedad ocupacional, incluso si usted la juzga para ser de menor importancia. Forme No. 8a WCA, aviso de lesión accidental o la enfermedad profesional, se puede utilizar para ese propósito (RSA 281-A:20,21). Después de que usted la haya terminado y haya puesto a disposición él o ella, su patrón debe recibo del acknowlege firmando y dándole una copia.
2 Le dan derecho a los servicios de un médico. Este médico estará dentro de una red manejada del cuidado, si RSA inferior aplicable 281-A:23a.
3 Usted no puede demandar a su patrón como resultado de lesión o de una enfermedad trabajar-conectada por causa de su elegibilidad para las ventajas debajo de Workers' Ley De la Remuneración.

A LOS PATRONES

1 Le requieren exhibir este cartel de modo que esté de la ventaja posible más grande a sus empleadso (RSA 281-A:4).
2 Le requieren archivar un informe de Employer's primer de lesión o de la enfermedad profesional, WC de la forma No. 8, con la comisión de trabajo, copia a la oficina más cercana de las demandas de su portador de seguro, en todas las lesiones o enfermedades ocupacionales dando por resultado una visita a un médico, con excepción de un médico de la casa, cuanto antes pero no más adelante de de cinco días después de la fecha del conocimiento (RSA 281-A:53i).
3 Le requieren divulgar a la comisión de trabajo, copia como en 2 arriba, cualquier inhabilidad ocupacional, si total o parcial, de cuatro o más días (RSA 281-A:22), en un informe suplemental de Employer's de lesión, forma No. 13 WCA, cuanto antes, pero no más adelante de diez días después de la fecha del conocimiento (RSA 281-A:53, i e II).
4 Le requieren equipar, o haga ser equipado, los servicios médicos y del hospital razonables, el otro cuidado remediador o los tipos vocacionales del rehabilitación, y varios de pensión por invalidez, a un empleado dañado o lisiado de acuerdo con RSA 281-A:23, 25, 26, 28, 29, 31, 32.
5 Todos los patrones con empleados 5 o más a tiempo completo desarrollarán las oportunidades alternativas temporales del trabajo para los empleados dañados de acuerdo con RSA 281-A:23-b. Los patrones pueden ser obligados reinstalar a empleados que sostienen lesión compensable de acuerdo con RSA 281-A:25-a.
6 Le requieren obtener del portador identificado debajo de una fuente de las formas de la remuneración de todos los trabajadores requeridos. AVISO - la violación de las varias provisiones de la ley de la remuneración de los trabajadores lleva penas, multas de la corte, o ambas civiles.

David M. Wihby
Diputado Labor Comisión

George N. Copadis
Comisión De trabajo

El patrón infrascrito da por este medio el aviso de la conformidad con todas las provisiones de la ley de la remuneración de los trabajadores y de las regulaciones administrativas de la comisión de trabajo del estado de New Hampshire conforme a los estatutos revisados anotados, capítulo 281-A, según la enmienda prevista.

Nombre de la compañía de seguros
O uno mismo -asegurador:

Global Casualty Company
888 Asylum Street
Hartford, CT 06543

Nombre del patrón:
Sample Corporation
432 Park Ave.
New York, NY 10020
253.630.1111

Por **Ronald T. Waxmen**

987654321
No. De la Identificación Del Patrón.
(si desconocido, patrón del número a solicitar el IRS)

Este aviso se debe fijar visible en y sobre el lugar de Employer's o los lugares del negocio
Prescrito por la comisión de trabajo
Estado de New Hampshire
WCP-1 (1-99)

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with the

Global Casualty Company
(Insurance Company Name)

for the period

Beginning 10/1/2007 **Ending** 10/1/2008

Employer Sample Corporation

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

AVISO

El patron avisa que ha asegurado el pago de compensación a los empleados y sus dependientes, de acuerdo con lo provisto por la ley de responsabilidad de los patrones de seguro para sus empleados. Titulo 34, Capitulo 15, Articulo 5, revision de estatutos del Estado de New Jersey, asegurandolos con

Global Casualty Company

(Compañia de Seguro)

por el periodo

Comenzando 10/1/2007 **Terminando** 10/1/2008

Patron Sample Corporation

De acuerdo con la ley mencionada arriba, esta noticia debe ser colocada y mantenida en un lugar visible en todos los lugares de trabajo.

State of New Mexico Workers' Compensation Administration

WORKERS' COMPENSATION ACT

If You Are Injured At Work
Si Se Lastima En El Trabajo

1) Notice -- In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form.

2) You have the right to information and assistance from an information specialist known as an Ombudsman at the Workers' Compensation Administration.

3) Claims information -- Contact your employer's Claims Representative.

1) Aviso. -- En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.

2) Usted tiene el derecho a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.

3) Información acerca de Reclamaciones. -- Contáctese con el representante de reclamaciones de su compañía.

Employer's Insurer / Claims Representative:

Name: Gallagher Bassett Services
Phone #: 630.773.3800
Address: Two Pierce Place
Itasca, IL 60143-3141

Note: Employer must fill in this insurer / claims representative information.

YOUR RIGHTS

If you are injured in a work-related accident:

Your employer / insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer / insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency, get emergency medical care first.

If you are off work for more than 7 days, your employer / insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

SUS DERECHOS

Si se lastima en el trabajo:

Su empleador / asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador / asegurador no le ha dado instrucciones por escrito de quien es él que selecciona primero, pregúntele o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador / asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un periodo de tiempo más largo.

Ombudsmen are located at the following offices:

Albuquerque:	Farmington:	Las Cruces:	Las Vegas:	Lovington:	Roswell:	Santa Fe:
1-800-255-7965	1-800-568-7310	1-800-870-6826	1-800-281-7889	1-800-934-2450	1-866-311-8587	1-505-476-7381
1-505-841-6000	1-505-599-9746	1-505-524-6246	1-505-454-9251	1-505-396-3437	1-505-623-3997	

If You Need HELP Call:

Ask for an Ombudsman

Si Usted Necesita Ayuda Llame Al:

Pregunte por un Ombudsman

1 - 8 6 6 - W O R K O M P (1-866-967-5667)

Visit our website at: www.workerscomp.state.nm.us

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667

USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR

EMPLOYER: You are required by law to post this poster where your employees can read it and to post Notice of Accident forms with it. This poster without Notice of Accident forms does not comply with law. You have other rights and duties under the law.

New Mexico Workers' Compensation Administration
2410 Centre Avenue, Albuquerque, New Mexico 87106
P.O. Box 27198, Albuquerque, New Mexico 87125-7198

POST FORMS HERE

This poster published 3/15/07. It remains valid until reissued and supersedes all prior versions except 3/15/03.

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

A T T E N T I O N

Brief Description of Your Rights and Benefits
If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1): If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer Hearing. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street**,** Suite 213, Carson City, NV 89701, (775) 687-4076, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For assistance with Workers' Compensation Issues: you may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http://govcha.state.nv.us, E-mail cha@govcha.state.nv.us

The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator: **Gallagher Bassett Services** Contact Person: **Claim Call Center**

Address: **Itasca** (City) **IL** (State) **60143-3141** (Zip) Telephone Number: **630.773.3800**

MCO/Health Care Provider: **United Health Care** Contact Person: **Victor Hugo**

Address: **Orem** (City) **UT** (State) **84051** (Zip) Telephone Number: **(414) 231-4410**

D-1 (rev. 11/05)

NOTICE TO EMPLOYEES

Pursuant to: NRS 616B.227 Election by employee to report his tips; effect; regulation.

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:
   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE
WORKERS' COMPENSATION LAW

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 - 100 Broadway-Menands - (866) 750-5157
***Brooklyn, 11201 - 111 Livingston St. - Brooklyn - (800) 877-1373**
Binghamton, 13901 - State Office Bldg. - 44 Hawley St. - (866) 802-3604
Buffalo, 14202 - Statler Tower, 107 Delaware Ave. - (866) 211-0645
***Hauppauge, 11788 - 220 Rabro Drive - Suite 100 - (866) 681-5354**
***Hempstead, 11550 - 175 Fulton Avenue - (866) 805-3630**
***New York, 10027 - 215 W.125th St., Manhattan - (800)-877-1373**
***Peekskill, 10566 - 41 North Division St. (866) 746-0552**
***Queens, 11432 - 168-46 91st Ave., Jamaica (800) 877-1373**
Rochester, 14614 - 130 Main Street West - (866) 211-0644
Syracuse, 13203 - 935 James St. - (866) 802-3730

***DOWNSTATE MAIL ADDRESS**

Claims-related mail for the Hauppauge, Hempstead, Peekskill and all NYC offices should be mailed to:

PO Box 5205 Binghamton, NY 13902-5205

AVISO DE CUMPLIMIENTO
LEY DE COMPENSACION OBRERA

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

DONNA FERRARA
CHAIR/PRESIDENTE

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

Global Casualty Company
888 Asylum Street
Hartford, CT 06543
800-555-1212

For Insurance Carriers ONLY: Policy No. **WCAI 571971**

Policy in Force from **10/1/2007** *to* **10/1/2008**

Name of employer (Nombre del patrono)

Sample Corporation

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (8-06)

Prescribed by Chairman
Workers' Compensation Board
State of New York

www.wcb.state.ny.us

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE
WORKERS' COMPENSATION LAW

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 - 100 Broadway-Menands - (866) 750-5157
***Brooklyn, 11201 - 111 Livingston St. - Brooklyn - (800) 877-1373**
Binghamton, 13901 - State Office Bldg. - 44 Hawley St. - (866) 802-3604
Buffalo, 14202 - Statler Tower, 107 Delaware Ave. - (866) 211-0645
***Hauppauge, 11788 - 220 Rabro Drive - Suite 100 - (866) 681-5354**
***Hempstead, 11550 - 175 Fulton Avenue - (866) 805-3630**
***New York, 10027 - 215 W.125th St., Manhattan - (800)-877-1373**
***Peekskill, 10566 - 41 North Division St. (866) 746-0552**
***Queens, 11432 - 168-46 91st Ave., Jamaica (800) 877-1373**
Rochester, 14614 - 130 Main Street West - (866) 211-0644
Syracuse, 13203 - 935 James St. - (866) 802-3730

***DOWNSTATE MAIL ADDRESS**

Claims-related mail for the Hauppauge, Hempstead, Peekskill and all NYC offices should be mailed to:

PO Box 5205 Binghamton, NY 13902-5205

AVISO DE CUMPLIMIENTO
LEY DE COMPENSACION OBRERA

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

DONNA FERRARA
CHAIR/PRESIDENTE

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

Global Casualty Company
888 Asylum Street
Hartford, CT 06543
800-555-1212

For Insurance Carriers ONLY: Policy No. **WCAI 571971**

Policy in Force from **10/1/2007** *to* **10/1/2008**

Name of employer (Nombre del patrono)

Sample Corporation

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (8-06)

Prescribed by Chairman
Workers' Compensation Board
State of New York

www.wcb.state.ny.us

OHIO BUREAU OF WORKERS' COMPENSATION

REQUIRED POSTING

Effective October 13, 2004, Section 4123.54 of the Ohio Revised Code requires notice of rebuttable presumption. Rebuttable presumption means that an employee may dispute or prove untrue the presumption (or belief) that alcohol or a controlled substance not prescribed by the employee's physician is the proximate cause (main reason) of the work-related injury.

The burden of proof is on the employee to prove that the presence of alcohol or a controlled substance was not the proximate cause of the work-related injury. An employee who tests positive or refuses to submit to chemical testing may be disqualified for compensation and benefits under the Workers' Compensation Act.

THIS LANGUAGE MUST BE POSTED WITH THE CERTIFICATE OF COVERAGE

Form 1A ***Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees***

All employees of this employer who are entitled to benefits of the Workers' Compensation Act are hereby notified that this employer has complied with all rules of the Workers' Compensation Court and that this employer has secured payment of compensation for all employees and their dependents in accordance with the Act. All employees are further notified this employer will furnish first aid, medical, surgical and any other like services required by law as well as payments of compensation to any injured employee as provided in the Workers' Compensation Act.

Any employee who has suffered a compensable injury covered by the Workers' Compensation Act shall be entitled to vocational rehabilitation services, including retraining and job placement, if, as a result of the injury, the employee is unable to perform the same occupational duties the employee was performing prior to the injury.

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or in-state toll free (800) 522-8210.

The Oklahoma Workers' Compensation Court has a counselor program to provide information to injured workers, employers, and other interested parties. Counselors assist unrepresented parties to enable them to protect their rights under the workers' compensation system.

Official Signature

Signature of Employer

Global Casualty Company
800-555-1212

Insurer & Insurer Phone Number

Employee's Responsibilities in Case of Accidental Injury or Occupational Disease

If accidentally injured or affected by an occupational disease arising out of and in the course of employment, however slight, the employee should notify the employer immediately. If this employer is a partnership, notice shall be given to any partner. If this employer is a corporation, notice shall be given to any agent or officer of the corporation upon whom legal process may be served. Notice shall also be given to the person in charge of business at the location of operations where the injury occurred. Unless notice is given to the employer or medical treatment is rendered within thirty (30) days of injury, any claim for compensation may be forever barred.

If accidentally injured or affected by an occupational disease, the employee may file a claim for compensation with the Workers' Compensation Court. This employer is required to furnish the employee with appropriate forms to file a compensation claim.

A claim for compensation must be filed with the court within a period of time specified by statute, or be forever barred. Based on statute effective July 1, 2005, if a claim for compensation for any accidental injury or death is not filed with the Court within two (2) years from the date of the accidental injury or death or if a claim for compensation for occupational disease or cumulative trauma is not filed within two (2) years of either the last hazardous exposure or from the date the disease first became manifest, which ever last occurred, the claim for compensation may be forever barred. Provided, claims may be filed within two (2) years from the date of the last medical treatment authorized by the employer or payment of any compensation or remuneration paid in lieu of compensation. Post termination claims must be filed within six (6) months of termination of employment.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

Employer's Responsibilities

The employer must provide employees with immediate first aid, medical and surgical care and other like services necessary. This applies to care for all injuries and illnesses arising out of and in the course of employment, regardless of their character. If an employee is injured and this results in the loss of time beyond his/her shift, or requires medical attention away from the work site (fatal or otherwise), the employer MUST file a Form 2 within ten (10) days of the notice of injury or a reasonable time thereafter. The employer must provide a copy of such Form 2 to the employer's workers' compensation insurance carrier, if any.

No agreement by any employee to pay any portion of premiums paid by the employer to maintain or carry compensation insurance as required by law shall be valid. Any employer who deducts money from the wages or salary of any employee for that purpose who is entitled to workers' compensation shall be guilty of a misdemeanor.

If the employer has notice of an undisputed injury and the employer's insurance carrier fails to commence weekly temporary total disability benefit payments due within the time provided by law, the insurer may be subject to a penalty of fifteen percent (15%) of the unpaid or delayed weekly benefits due and payable to the employee.

No agreement by any employee to waive workers' compensation rights and benefits shall be valid.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Workers' Compensation Court
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
(405) 522-8600 WATS # 1-800-522-8210

07/05

This notice must be posted and maintained by the employer in one or more conspicuous places.

Forma 1A

Aviso E Instrucciones Para Todos Los Empleadores Y Trabajadores Sobre La Compensación Para Los Trabajadores De Oklahoma

Todos los trabajadores (los empleados) de este empleador (de este patrón) que tengan el derecho a recibir beneficios del Acta de Compensación para los Trabajadores son avisados por esta notificación que este empleador ha cumplido con todas las reglas de la Corte de Compensación para los Trabajadores y que este empleador ha obtenido pagos de compensación para todos los trabajadores y sus mantenidos de acuerdo con el Acta. También se les notifica a todos los trabajadores que este empleador proveerá primeros auxilios, servicios de asistencia médica y quirúrgica, y otros servicios similares requeridos por la Ley, así como pagos de compensación para los Trabajadores a cualquier trabajador lesionado (lastimado) tal como lo indica el Acta de Compensación de Trabajadores.

Cualquier trabajador que haya sufrido cubierta por el Acta de Compensación para los Trabajadores, tendrá el derecho a recibir servicios de enseñanza de oficios (rehabilitación profesional), incluyendo readiestramiento y colocación de empleo, si, con motivo de una lesión, el trabajador no puede desempeñar los mismos deberes profesionales que el trabajador desempeñaba entes de la lesión. La denegación de aceptar servicios de rehabilitación por parte del trabajador no disminuye en lo más mínimo los beneficios permisibles para el trabajador.

NOTA: Mediación es disponible en ciertos conflictos de compensación laboral, que pone a la disponibilidad de los trabajadores la Corte de Compensación. Los interesados deben llamar al (405) 522-8760 o al llamada gratis dentro de este estado (800) 522-8210 (llamada gratis) para más información.

La Corte de Compensación para los Trabajadores de Oklahoma tiene un equipo de consejeros (asesores) para proveerles información a los trabajadores lesionados y a los empleadores y otras partes interesadas. Consejeros suministran ayuda a las personas no representadas por abogados para protegerles sus derechos bajo el sistema de Compensación de Trabajadores.

Official Signature

Firma del Patrón

Global Casualty Company

800-555-1212

Compañía de Seguros
Número Telefónico de la Compañía de Seguros

Las Responsabilidades De Los Trabajadores En Caso De Lesión Accidental O Enfermedad Profesional

Si se lesiona (se lastima) accidentalmente o es afectado por una enfermedad profesional como resultado de, o en el transcurso de, su empleo, aún si es leve, el trabajador debe notificarle al empleador inmediatamente. Si dicho empleador es una sociedad colectiva, se le puede dar notificación a cualquier socio. Si el empleador es una sociedad anónima (corporación), se debe notificar a cualquier agente u oficial de la corporación autorizado a recibir notificación. También se debe dar notificación a la persona que esté a cargo del negocio en el lugar de operación del negocio en donde ocurrió la lesión. A menos que se le haya otorgado notificación al empleador o que se haya otorgado asistencia médica dentro de un plazo de treinta (30) días a partir de la lesión, cualquier reclamo por compensación podría estar exceptuado.

Si el trabajador se lesiona o es afectado por una enfermedad profesional, puede presentarle un reclamo para compensación a la Corte de Compensación para los Trabajadores. El empleador está requerido a proveerle al trabajador las formas apropiadas (los formularios) para poder presentar el reclamo de compensación.

Cualquier pretensión por compensación debe de entablarse con la Corte dentro del plazo de tiempo especificado por los Estatutos, o si no puede ser precluido indefinidamente a base de los Estatutos vigentes el 1 de Julio, 2005, si el trabajador no presenta el reclamo (la demanda) de compensación por lesión accidental o muerte dentro de un plazo de dos (2) años a partir desde la fecha del accidente, lesión o muerte, o si no se presenta un reclamo (demanda) por enfermedad profesional o por trauma cumulativo dentro de un plazo de dos (2) años desde la fecha en que estuvo expuesto al peligro por última vez o la fecha en que la enfermedad se manifestó por primera vez, cual ocurriera último, su reclamo (demanda) de compensación podría ser invalidado permanentemente. Sin embargo, se puede presentar un reclamo dentro de un plazo de dos (2) años a partir del último tratamiento médico rendido por el empleador de pago por cualquier compensación, o remuneración en lugar de compensación. Reclamos o pretensiones realzadas posteriormente al despido deben de ser entabladas dentro de un plazo de seis (6) meses depués del despido del empleo.

Cualquier persona que reciba beneficios de incapacidad temporal de un empleador, o de la compañía de seguros ("aseguranza") que asegure al trabajador, deberá reportarle sin demora por escrito al patrón o a la compañía de seguros cualquier cambio en los hechos pertinentes, cambio en la cantidad de ingresos que el trabajador esté recibiendo, o cambio en su situación de empleo, que ocurra durante el plazo de tiempo en el que el trabajador esté recibiendo dichos beneficios.

Responsabilidades Del Empleador

El empleador debe rendirle de inmediato a los trabajadores primeros auxilios, atención médica, cirugía y otros servicios similares cuando sea necesario. Esto es igualmente aplicable para todas las lesiones y enfermedades que resulten del empleo o durante la labor, sin importar de que tipo sean. Si un trabajador se lesiona (se lastima) y esto resulta en que el trabajador pierda tiempo de trabajo, además del tiempo perdido en su turno de trabajo, o requiere asistencia médica en un lugar fuera del sitio de trabajo (lesión mortal o no), el empleador ESTA OBLIGADO a presentar la Forma 2 dentro de un plazo de diez (10) días a partir del día en que se le notificó que había ocurrido la lesión, o después de un plazo de tiempo razonable. El empleador debe suministrar presentar una copia de dicha Forma 2 a la compañía de seguros de Compensación para los Trabajadores, si tiene alguna.

No será válido ningún acuerdo entre un empleador y un trabajador de compartir el pago para mantener en vigor el seguro de compensación tal como lo requiere la Ley. Cualquier empleador que tome deducciones de dinero del sueldo o salario de un trabajador que tenga derecho a la compensación de trabajadores será culpable de un delito menor.

Si el empleador tiene notificación de una lesión incontrovertible y la compañía de seguros del trabajador falla en iniciar los pagos por beneficios semanales de incapacidad total temporal dentro del plazo de tiempo que requiere la Ley, la compañía de seguros puede estar sujeta a la imposición de una sanción del quince por ciento (15%) de los beneficios semanales impagados o pospuestos vencidos y pagaderos al trabajador.

Nunca se considerará válido ningún acuerdo por parte de cualquier trabajador a renunciar a sus derechos o beneficios de compensación para los trabajadores.

Cualquier persona que cometa fraude de compensación para los trabajadores, una vez se le haya procesado, será culpable de un delito mayor.

Workers' Compensation Court
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
(405) 522-8600 WATS # 1-800-522-8210

08/05

Este aviso será puesto y mantenido por el empleador en uno o más lugares conspicuos.

DEPARTMENT OF
LABOR & INDUSTRY
COMMONWEALTH OF PENNSYLVANIA

BUREAU OF WORKERS' COMPENSATION
1171 SOUTH CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501

717-772-0621 www.dli.state.pa.us

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR EMPLOYER'S WORKERS' COMPENSATION INSURANCE COMPANY, THIRD-PARTY ADMINISTRATOR (TPA), OR PERSON HANDLING WORKERS' COMPENSATION CLAIMS FOR YOUR COMPANY, ARE CONTAINED BELOW.

EMPLOYER NAME: Sample Corporation **DATE POSTED:** _____

IF INSURED:
(Complete all applicable spaces)

NAME OF INSURANCE COMPANY:
Global Casualty Company

ADDRESS:
888 Asylum Street
Hartford, CT 06543

TELEPHONE NUMBER: 800-555-1212

INSURER'S BUREAU CODE: 1234

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

NAME OF TPA (Claims administrator):
Gallagher Bassett Services

ADDRESS:
Two Pierce Place
Itasca, IL 60143-3141

TELEPHONE NUMBER: 630.773.3800

IF SELF-INSURED:
(Complete all applicable spaces)

NAME OF PERSON HANDLING CLAIMS AT THE SELF-INSURED:

ADDRESS:

TELEPHONE NUMBER: _____

SELF-INSURED BUREAU CODE: _____

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

NAME OF TPA (Claims administrator):

ADDRESS:

TELEPHONE NUMBER: _____

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

STATE OF RHODE ISLAND
DEPARTMENT OF LABOR & TRAINING

This employer is subject to the provisions of the

WORKERS' COMPENSATION ACT

of the State of Rhode Island

Workers' Compensation Insurance Company: Global Casualty Company

Adjusting Company: Gallagher Bassett Services

Telephone: 630.773.3800 Policy Effective Date: 10/1/2007

In accordance with Rhode Island General Law §28-32-1, the **employer must report** to the Director of Labor and Training **every personal injury sustained by an employee if the injury incapacitates the employee from earning full wages for at least three (3) days or requires medical treatment, regardless of the period of incapacity.** If the injury proves fatal, the report must be filed within forty-eight (48) hours. If not fatal, the report shall be made within ten (10) days of the injury.

An injured employee shall have the freedom to choose medical treatment initially. The employee's first visit to any facility under contract or agreement with the employer or insurer to provide priority care **shall not be considered** the employee's initial choice.

For more information about Workers' Compensation procedures and benefits, call the Education Unit at (401) 462-8100 and press option #1 or TDD (401) 462-8006. If you suspect fraud, contact the Fraud Prevention Unit at (401) 462-8100 and press option #7.

In accordance with Rhode Island General Law §28-29-13, this notice must be posted and maintained in conspicuous places where workers are employed.
Fines may be imposed for noncompliance.

DWC-8 (5/2004)

DEPARTAMENTO DE TRABAJO Y ENTRENAMIENTO DEL ESTADO DE RHODE ISLAND

Esta empresa esta sujeta a las estipulaciones del

ACTA DE COMPENSACION DE TRABAJADORES

del Estado de Rhode Island

Seguro de Compensación de Trabajo **Global Casualty Company**

Compañía Ajustadora: **Gallagher Bassett Services**

Teléfono: **630.773.3800** Fecha Efectiva de Póliza: **10/1/2007**

De acuerdo con las Leyes Generales de Rhode Island §28-32-1, **las empresas tienen que reportarle** al Director de Trabajo y Entrenamiento **cada lesión personal reportada por un empleado si la lesión incapacita al empleado de ganar un sueldo completo por un mínimo de tres (3) días, o requiere tratamiento médico, sin importar el período de incapacidad.** Si la lesión es fatal, el incidente debe ser reportado dentro de cuarenta y ocho (48) horas. Si no es fatal, el incidente será reportado dentro de diez (10) días de la lesión.

Un empleado lesionado tiene la libertad de escoger al primer proveedor médico. La primera visita del empleado a cualquier centro de atención médico contratado por la empresa o la aseguradora, con la intención de facilitar atencíon inmediata, **no será considerado** el primer proveedor médico.

Para más información referente a la compensación para trabajadores a causa de accidentes de trabajo, procedimientos y beneficios, llame a la Unidad Educacional al (401) 462-8100 y apriete la opción #1 o TDD (401) 462-8006. Si usted sospecha de fraude, póngase en contacto con la Unidad de Prevención de Fraude al (401) 462-8100 y apriete la opción #7.

De acuerdo con las Leyes Generales de Rhode Island §28-29-13, este aviso debe ser colocado y mantenido en lugares visibles para los trabajadores. Las empresas que no cumplan con este requerimiento pueden ser sujetas a multas.

DWC-8 S (5/2004)

Workers' Compensation

If you are injured on the job, you should:

1. Notify your employer at once. You can't receive benefits unless your employer knows you're injured.
2. Tell the doctor your employer sends you to that you're covered by Workers' Comp.
3. Notify the Workers' Comp. Provider below or the S.C. Workers' Comp. Commission at (803) 737-5700 if you experience undue delays or problems with your claim.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

We are operating under and subject to the
S.C. Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

S.C. Workers' Compensation Commission
P.O. Box 1715, 1612 Marion Street
Columbia, S.C. 29202-1715
(803) 737-5700
www.wcc.state.sc.us

Workers' Compensation Provider Name, Address, & Claims Telephone #:

Global Casualty Company
888 Asylum Street
Hartford, CT 06543
630.773.3800

Compensación del Trabajador

Si usted se lesiona en el trabajo, usted debe:

1. Notificar a su patrón inmediatamente. Usted no puede recibir beneficios a menos que su patrón sepa que se ha lesionado.
2. Decirle al doctor al que su patrón le envíe que usted está cubierto por la Compensación del Trabajador.
3. Notificar al Proveedor de Compensación del Trabajador abajo mencionado o a la Comisión de Compensación del Trabajador de Carolina del Sur al (803) 737-5700 si usted tiene retrasos o problemas indebidos con su reclamación.

La Compensación del Trabajador:

1. Paga el 100% de sus recibos médicos y otros gastos.
2. Le compensa por el 66 2/3% de su salario, limitado al salario máximo establecido por la ley, si usted no puede trabajar por más de siete (7) días calendario.

Trabajamos conforme al Acto de Compensación del Trabajador de Carolina del Sur

En caso de lesión accidental o muerte de un empleado, el empleado lesionado, o alguien que le represente, tiene que avisar inmediatamente al patrón o agente autorizado general. El hecho de no avisar inmediatamente puede causar una demora seria en el pago de la compensación al empleado lesionado o a sus dependientes y puede resultar en el impago de los beneficios de compensación según estipula la ley.

S.C. Workers' Compensation Commission
(Comisión de Compensación de Trabajadores)
P.O. Box 1715, 1612 Marion Street
Columbia, SC 29202-1715
(803) 737-5700
www.wcc.state.sc.us

Global Casualty Company
888 Asylum Street
Hartford, CT 06543
630.773.3800

Workers' Compensation

A SAFE & HEALTHFUL WORKPLACE BEGINS WITH YOU!

POLICY: It is our policy to have a safe and healthful workplace. We have implemented an injury and illness prevention program for your protection and the protection of fellow workers.

GOAL: Our main goal is to prevent accidents and illnesses in the workplace. Employees and members of management are expected to follow all requirements of Federal, state and local governments to ensure a safe environment.

COMMUNICATION: We have made a commitment to provide a safe workplace and encourage you to make suggestions so that we can maintain a policy of prevention. If you have any questions, please contact the following persons in charge of safety at this company.

SAFETY DIRECTOR: Ronald T. Waxmen

PHONE: 253.630.1111

SAFETY SUPERVISOR: _____

PHONE: _____

SAFETY MEETINGS

Employees will meet on a regular basis to receive safety training and information about our company's safety policies and procedures. Attendance at all scheduled safety training and information meetings is mandatory.

TENNESSEE WORKERS' COMPENSATION INSURANCE

Employers: The law requires this notice to be conspicuously posted at the employer's place of business so all employees have access to it.

WHO IS REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE?

All employers with five (5) or more full or part-time employees.
All employers engaged in the mining and production of coal with one (1) or more employees.
All contractors in the construction industry with one (1) or more employees.

To confirm if an employer is subject to the workers' compensation law and if so to obtain the name of the workers' compensation insurance company contact:

Ronald T. Waxmen
Name of employer representative authorized to provide information on workers' compensation

253.630.1111
Telephone number of employer representative to provide information on workers' compensation

1010 N Captain Way, Building 1A-393, Houston, TX 32001
Address of employer representative to provide information on workers' compensation

WHAT SHOULD AN EMPLOYEE DO IF INJURED AT WORK?

1. Report the injury to the employer immediately. Employer notification is required.

and 2. Select a treating physician from a panel provided by the employer.

To report an injury contact:

Ronald T. Waxmen
Name of employer representative to notify in event of a work related injury

253.630.1111
Telephone number of employer representative to notify in event of a work related injury

1010 N Captain Way, Building 1A-393, Houston, TX 32001
Address of employer representative to notify in event of a work related injury

WHAT SHOULD AN EMPLOYER DO WHEN AN INJURY IS REPORTED?

1. Immediately complete a First Report of Work Injury form and send it to the workers' compensation insurance company or the third party administrator to be filed with the Tennessee Dept. of Labor and Workforce Development, Workers' Compensation Division.

and 2. Offer a panel of physicians.

The employer shall designate a group of three (3) or more physicians or surgeons not associated together in practice from which the injured employee shall have the privilege of selecting the operating surgeon or the attending physician. If the injury is a back injury, the panel shall be expanded to four (4), one of whom must be a doctor of chiropractic. If a doctor of chiropractic is chosen, chiropractor visits may be authorized for up to twelve (12) visits per back injury. More than twelve (12) visits to such doctor of chiropractic must be specifically approved by the employer or insurance carrier. The provisions for chiropractic care shall not apply to workers' compensation self insurer pools established pursuant to Section 50-6-405(a)(1). If the injury requires the treatment of physician or surgeon who practices orthopedic or neuroscience medicine then the employer may appoint a panel of physicians or surgeons practicing orthopedic or neuroscience medicine consisting of five (5) physicians, with no more than four (4) physicians affiliated in practice together. The employee may select a treating physician or surgeon from the employer panel.

The Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, has staff available to help both employees and employers. For more information contact:

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243
615-532-4812 OR TOLL FREE 1-800-332-2667 OR 1-800-332-2257 (TDD)
www.state.tn.us/labor-wfd/wcomp.html

LB-0922 (rev. 08/05)

SEGURO DE ACCIDENTES DE TRABAJO DE TENNESSEE

Empleadores: La ley exige que se ponga este aviso en un lugar del negocio del empleador bien visible para que todos los empleados tengan acceso al mismo.

¿QUIÉNES ESTÁN OBLIGADOS A TENER SEGURO DE ACCIDENTES DE TRABAJO?

Todo empleador que tenga cinco (5) o más de cinco empleados de horario completo o de medio horario. Todo empleador que se dedique a la explotación de minas y la producción de carbón que tenga un (1) empleado o más de un empleado.

Todo empresario de la industria de la construcción que tenga un (1) empleado o más de un empleado.

Para comprobar si un empleador está sujeto a la ley de accidentes de trabajo y si ese fuera el caso, para obtener el nombre de la compañía de seguro de accidentes de trabajo a contactar:

Ronald T. Waxmen

Nombre del representante del empleador

253.630.1111

Número de teléfono del representante del empleador

1010 N Captain Way, Building 1A-393, Houston, TX 32001

Dirección del representante del empleador

(el nombre, la dirección y el número de teléfono del representante del empleador autorizado a dar información sobre indemnización por accidentes de trabajo)

¿QUÉ DEBE HACER UN EMPLEADO SI SE LESIONA EN EL TRABAJO?

1. Notificar al empleador de la lesión inmediatamente. Es obligatorio notificar al empleador.

y 2. Escoger a un médico que le atienda de la lista que le dé el empleador.

Para notificar una lesión póngase en contacto con:

Ronald T. Waxmen

Nombre del representante del empleador

253.630.1111

Número de teléfono del representante del empleador

1010 N Captain Way, Building 1A-393, Houston, TX 32001

Dirección del representante del empleador

(el nombre, la dirección y el número de teléfono del representante del empleador autorizado a dar información sobre indemnización por accidentes de trabajo)

¿QUÉ DEBE HACER EL EMPLEADOR CUANDO SE LE NOTIFICA DE UNA LESIÓN?

1. Llenar inmediatamente el formulario Primera Notificación de Accidente de Trabajo y enviarlo a la compañía de seguro de accidentes de trabajo o al administrador del seguro contra tercera persona para que lo registre en el Departamento de Trabajo y Desarrollo Laboral de Tennessee, División de Accidentes de Trabajo.

y 2. Ofrecer una lista de médicos.

El empleador deberá nombrar un grupo de tres (3) médicos o cirujanos o más que no estén afiliados a la misma oficina y de los cuales el empleado lesionado tendrá el privilegio de escoger ya sea el médico que le va a atender o el cirujano que le va a operar. Si la lesión es una lesión de la espalda, la lista aumentará a cuatro (4), entre los cuales habrá un médico quiropráctico. Si ud escoje un médico quiropráctico, las visitas pueden ser autorizadas hasta doce (12) vezes por la lesión de espalda. Si ud require más de doce (12) visitas al mismo médico quiropráctico tendra que tener autorización de su justador de seguransa or empleador. Las provisiones para el cuidado del quiropráctico no se aplicarán grupos de autoasegurador establecidas conforme a la Sección 50-6-405 (a) (1). Si es una lesión que requiere que le atienda un médico o cirujano que ejerce la medicina ortopédica o de neurociencias, entonces el empleador deberá nombrar un grupo de cinco (5) médicos o cirujanos que ejercen la medicina ortopédica o de neurociencias de entre los cuales sólo cuatro (4) pueden estar afiliados a la misma oficina. El empleado puede escoger un médico o cirujano de la lista del empleador para que le atienda.

El Departamento de Trabajo y Desarrollo Laboral de Tennessee, División de Accidentes de Trabajo tiene trabajadores disponibles para ayudar tanto al empleado como al empleador. Si necesita más información, favor de ponerse en contacto con:

DEPARTAMENTO DE TRABAJO Y DESARROLLO LABORAL DE TENNESSEE
DIVISIÓN DE ACCIDENTES DE TRABAJO
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243
615-532-4812 O LLAME GRATIS AL 1-800-332-2667 O AL 1-800-332-2257 (TDD)
www.state.tn.us/labor-wfd/wcomp

LB-0922 (rev. 03/06)

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Sample Corporation] has workers' compensation insurance coverage from
(Name of Employer)

[Global Casualty Company] protect you in the event of work-related injury or illness. This coverage is effective from [10/1/2007].
(Name of Commercial Insurance Company) (Effective Date of Policy)

Any injuries or illnesses which occur on or after that will be handled by [Global Casualty Company]. An employee or a person acting on the employee's behalf must notify the employer of an injury or illness not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an illness, unless the Division determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.
(Name of Commercial Insurance Company)

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will explain your rights and responsibilities under the Workers' Compensation Act and assist in resolving disputes about a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031.

SAFETY HOTLINE: The Division has established a 24-hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Health and Safety at 1-800-452-9595.

AVISO A EMPLEADOS SOBRE COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Sample Corporation]
Nombre del empleador

tiene cobertura de seguros de compensación para trabajadores con [Global Casualty Company] para protegerlo en caso de una
Nombre de la compañía de seguros

lesión o enfermedad relacionada con su trabajo. Esta cobertura está vigente desde el [10/1/2007]. Cualquier lesión o enfermedad, que ocurra en o a partir de esta fecha
Fecha en que entra en vigencia la póliza

será manejada por [Global Casualty Company]. El empleado
Nombre de la compañía de seguros

o la persona que lo representa debe notificar al empleador cuando el empleado sufre una lesión o enfermedad en el trabajo a no más tardar de treinta (30) días después de que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad, al menos que la División determine que existe un buen motivo para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador está obligado a proporcionarle información acerca de la cobertura de seguro de compensación, por escrito cuando usted es contratado o cuando su empleador adquiere o deje de tener cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División le proporciona información gratuita sobre como someter un reclamo de compensación para trabajadores. El personal de la División le explicará cuales son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores de Texas y le asistirá para resolver disputas relacionadas con su reclamo. Usted puede obtener este tipo de asistencia comunicándose con la oficina local de la División al teléfono 1-800-252-7031.

LÍNEA PARA REPORTAR CONDICIONES INSEGURAS: La División ha establecido una línea gratuita telefónica que está en servicio las 24 horas del día, para reportar condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen al empleado o empleada porque el o ella, de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al teléfono 1-800-452-9595.

REQUIRED WORKERS' COMPENSATION COVERAGE

The law requires that each person working on this site or providing services related to this construction project must be covered by workers' compensation insurance. This includes persons providing, hauling, or delivering equipment or materials, or providing labor or transportation or other services related to the project, regardless of the identity of their employer or status as an employee.

Call the Division of Workers' Compensation at 512-804-4345 to receive information on the legal requirement for coverage, to verify whether your employer has provided the required coverage, or to report an employer's failure to provide coverage.

COBERTURA REQUERIDA DE COMPENSACIÓN PARA TRABAJADORES

La ley requiere que cada persona que trabaja en este lugar o que proporciona servicios relacionados con este proyecto de construcción debe estar cubierta por un seguro de compensación para trabajadores. Esto incluye a personas que proporcionan, transportan, o entregan equipo o materiales, o que proporcionan mano de obra, u otros servicios relacionados con este proyecto, sin importar la identidad del empleador o el estado como empleado.

Comuníquese con la División de Compensación para Trabajadores al teléfono 512-804-4345 para recibir información referente a los requerimientos legales de cobertura, para verificar si su empleador ha proporcionado la cobertura requerida, o para reportar a un empleador que no proporciona cobertura.

TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
NOTICE REGARDING CERTAIN WORK-RELATED COMMUNICABLE DISEASES AND ELIGIBILITY FOR WORKERS' COMPENSATION BENEFITS

TO: Law Enforcement Officers, Fire Fighters, Emergency Medical Service Employees, Paramedics, and Correctional Officers -

IN ORDER TO QUALIFY FOR WORKERS' COMPENSATION BENEFITS, AN EMPLOYEE WHO CLAIMS A POSSIBLE WORK-RELATED EXPOSURE TO A REPORTABLE DISEASE, INCLUDING HIV INFECTION, MUST BE TESTED FOR THE DISEASE NOT LATER THAN THE 10TH DAY AFTER THE EXPOSURE AND MUST PROVIDE THEIR EMPLOYER WITH DOCUMENTATION OF THE TEST AND A SWORN AFFIDAVIT OF THE DATE AND CIRCUMSTANCES OF THE EXPOSURE. THE TEST RESULT MUST INDICATE THE ABSENCE OF THE DISEASE. THE EMPLOYEE IS NOT REQUIRED TO PAY FOR THE TEST.

Reportable diseases are those communicable diseases and health conditions required to be reported to the Texas Department of Health. Exposure criteria and testing protocol must conform to Texas Department of Health requirements.

TO: All State Employees -

IN ORDER TO QUALIFY FOR WORKERS' COMPENSATION BENEFITS, A STATE EMPLOYEE WHO CLAIMS A POSSIBLE WORK-RELATED EXPOSURE TO HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, MUST BE TESTED FOR HIV WITHIN 10 DAYS AFTER THE EXPOSURE AND MUST PROVIDE THEIR EMPLOYER WITH DOCUMENTATION OF THE TEST AND A WRITTEN STATEMENT OF THE DATE AND CIRCUMSTANCES OF THE EXPOSURE. THE TEST RESULT MUST INDICATE THE ABSENCE OF HIV INFECTION. THE EMPLOYEE IS NOT REQUIRED TO PAY FOR THE TEST.

FOR ADDITIONAL INFORMATION: TALK TO YOUR EMPLOYER OR CALL THE TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION AT 1-800-372-7713. ALSO, CONTACT THE TEXAS DEPARTMENT OF HEALTH (TDH) TO ENSURE FULL COMPLIANCE WITH THE HEALTH AND SAFETY CODE AND TDH RULES.

DEPARTAMENTO DE SEGUROS DE TEXAS,
DIVISIÓN DE COMPENSACIÓN PARA TRABAJADORES

AVISO REFERENTE A CIERTAS ENFERMEDADES CONTAGIOSAS RELACIONADAS CON EL TRABAJO Y LA ELEGIBILIDAD PARA OBTENER BENEFICIOS DE COMPENSACIÓN PARA TRABAJADORES

PARA: **Policías, Bomberos, Empleados del Servicio de Ambulancia Paramédicos, y Oficiales del Departamento de Correccionales -**

PARA PODER CALIFICAR PARA RECIBIR BENEFICIOS DE COMPENSACIÓN PARA TRABAJADORES, EL EMPLEADO QUE RECLAMA QUE POSIBLEMENTE FUE EXPUESTO A UNA ENFERMEDAD QUE DEBE SER REPORTADA, INCLUYENDO INFECCIÓN DEL VIRUS DEL VIH, DEBERÁ SER EXAMINADO A NO MÁS TARDAR DEL 10º DÍA DESPUÉS DE QUE HAYA SIDO EXPUESTO Y DEBERÁ PROPORCIONAR AL EMPLEADOR DOCUMENTACIÓN DEL EXAMEN Y UNA COPIA NOTARIADA CON LA FECHA Y CIRCUNSTANCIAS DE LA CAUSA POR LA CUAL FUE EXPUESTO. EL RESULTADO DEL EXAMEN DEBE INDICAR LA AUSENCIA DE LA ENFERMEDAD. NO ES REQUERIDO QUE EL EMPLEADO PAGUE POR EL EXAMEN.

Las enfermedades reportadas son todas las enfermedades contagiosas y condiciones de salud que requieren ser reportadas a la Comisión de Salud y Servicios Humanos de Texas (H&HSC, por sus siglas en inglés). El criterio para estar expuesto y el protocolo del examen debe cumplir los requisitos del H&HSC.

PARA: **Todos los Empleados Estatales**

PARA PODER CALIFICAR PARA BENEFICIOS DE COMPENSACIÓN PARA TRABAJADORES, EL EMPLEADO ESTATAL QUE RECLAMA QUE POSIBLEMENTE HA SIDO EXPUESTO AL VIRUS DE INMUNODEFICIENCIA HUMANA (VIH) Y QUE ESTÁ RELACIONADO CON EN TRABAJO, DEBERÁ HACERSE UNA PRUEBA DEL VIH DENTRO DE 10 DÍAS DESPUÉS DE QUE FUE EXPUESTO Y DEBERÁ PROPORCIONAR AL EMPLEADOR DOCUMENTACIÓN DEL EXAMEN Y UNA DECLARACIÓN POR ESCRITO CON LA FECHA Y CIRCUNSTANCIA DE LA CAUSA POR LA CUAL FUE EXPUESTO. EL RESULTADO DE LA PRUEBA DEBE INDICAR LA AUSENCIA DE INFECCIÓN DEL VIH. NO ES REQUERIDO QUE EL EMPLEADO PAGUE POR EL EXAMEN.

PARA MAYOR INFORMACIÓN: HABLE CON SU EMPLEADOR O LLAME AL DEPARTAMENTO DE SEGUROS DE TEXAS, DIVISIÓN DE COMPENSACIÓN PARA TRABAJADORES AL 1-800-372- 7713. TAMBIÉN, COMUNÍQUESE CON LA COMISIÓN DE SALUD Y SERVICIOS HUMANOS PARA ASEGURARSE QUE LOS REQUISITOS DE LAS REGLAS DE SALUD Y SEGURIDAD DEL H&HSC HAN SIDO CUMPLIDOS.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: (_____Sample Corporation_____) has elected not to
Name of Employer
obtain workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY HOTLINE: The Division has established a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Workers' Health & Safety at 1-800-452-9595.

AVISO A EMPLEADOS SOBRE COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Sample Corporation] ha elegido no
Nombre del Empleador

obtener cobertura de compensación para trabajadores. Como empleado de un empleador que ha elegido no obtener seguro de compensación para trabajadores usted no es elegible para recibir beneficios de compensación bajo la Ley de Compensación para Trabajadores de Texas. Sin embargo, un empleador sin cobertura puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener información acerca de la disponibilidad de otros beneficios o compensación por una lesión o enfermedad relacionada con el trabajo. Además, usted puede tener derechos bajo la ley de "Derecho Común" de Texas, si usted ha sufrido una lesión o enfermedad relacionada con su trabajo. Es requerido que su empleador le proporcione información acerca de la cobertura, por escrito, cuando es contratado o cuando su empleador obtiene o deja de tener cobertura de seguros de compensación para trabajadores.

LÍNEA DIRECTA PARA REPORTAR CONDICIONES INSEGURAS: La División ha establecido una línea telefónica gratuita las 24 horas, para reportar condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen contra un empleado o empleada porque él o ella, de buena fe, reporta una presunta violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al teléfono 1-800-452-9595.

NOTICE
THAT

Employer: **Sample Corporation**
has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act by insuring with Insurance Carrier: **Global Casualty Company**
Policy Number: **WCAI_571971**
Address for the above insurance carrier is **888 Asylum Street, Hartford, CT 06543**
Telephone number is **800-555-1212**

WORKERS' COMPENSATION

IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICAL BILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury - no matter how slight - to your boss immediately. (You may lose your rights if your injury is not reported promptly.)

2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the insurance company within seven (7) days of the accident.

3. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.

4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.

2. Ask your doctor to send a medical report to that insurance company.

3. Ask your employer to send a report of the accident to that insurance company.

4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation

REHABILITATION

IF YOU CANNOT RETURN TO WORK, YOU MAY BE ELIGIBLE FOR A REHABILITATION PROGRAM – CALL YOUR INSURANCE CARRIER AS LISTED ABOVE.

FRAUD

"For your protection, Utah Law requires the following to appear on this form, any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

STATE OF UTAH

LABOR COMMISSION

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610
(801)530-6800 – (800)530-5090 – (801)530-7685 TDD

If you want an Employee's Guide to Workers' Compensation or have questions, call the Labor Commission at the above listed numbers.

NOTE: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204, Utah Code Annotated, 1997.

NOTE QUE

La empresa: Sample Corporation

Ha cumplido con las provisiones del Acta de Compensación al Trabajador, Título §34A-2-101, en el libro de Código de Utah anotado en 1997, y las reglas de la Comisión de Labor (Labor Commission), y ha asegurado tener la responsabilidad de pagar compensación y otros beneficios preve idos por el Acta ya mencionada al tener cobertura con.

Compañía de Seguros: Global Casualty Company **No. de Póliza:** WCAI_571971

Dirección de la compañía de seguros: 888 Asylum Street, Hartford, CT 06543

Número de teléfono: 800-555-1212

COMPENSACION AL TRABAJADOR

ES EL SEGURO EL CUAL LE PROTEGE DURANTE EL TRABAJO. SI TIENE UN ACCIDENTE EN EL TRABAJO O UNA ENFERMEDAD GENERADA A CAUSA DE SU TRABAJO, SU SEGURO PAGARA POR: HOSPITAL Y GASTOS MEDICOS • INCAPACIDAD • PERDIDA PERMANENTE DE UNA FUNCION DE SU CUERPO • PROTESIS • GASTOS DEL FUNERAL EN CASO DE MUERTE.

COMO REPORTAR UN ACCIDENTE

1. Reporte la herida - no importa que tan leve sea - a su supervisor inmediatamente. (Pierde sus derechos si no reporte su accidente entre 180 días después del incidente.)
2. Pida a su supervisor que llene la forma del primer reporte de accidente. Una copia de este reporte es para usted y las demás copias deben ser enviadas a La Comisión de Labor y a la compañía de seguro dentro de los primeros siete (7) días del accidente.
3. Si en su trabajo hay un cuarto de primeros auxilios o un doctor de la compañía, vaya allá inmediatamente para obtener tratamiento, Si no, vaya al doctor de su preferencia.
4. Dígale al doctor **CÓMO, CUÁNDO Y DÓNDE** ocurrió el accidente. El doctor llenará una forma de reporte médico. Copias de ese reporte deben se enviadas dentro de siete (7) días de su visita a (1) la compañía de seguros, (2) La Comisión de Labor y (3) usted, el empleado.

COMO EMPEZAR LA COMPENSACION

1. Pregunte a su supervisor cual es la compañía de seguros que paga Compensación al Trabajador de su trabajo.
2. Pida a su doctor que mande un reporte médico a esa compañía de seguros.
3. Pida a su supervisor que mande un reporte del accidente a esa compañía de seguros.
4. Llame a la compañía de seguros y pídales que empiecen sus beneficios de compensación al trabajador. La compañía de seguros requerirá el reporte del doctor, el reporte de su trabajo, y le pedirá que llene una forma para obtener compensación.

REHABILITACION

SI NO PUEDE REGRESAR A SU TRABAJO, USTED PUEDE CALIFICAR PARA UN PROGRAMA DE REHABILITACION - LLAME A LA COMPAÑÍA DE SEGUROS MENCIONADA ARRIBA.

FRAUDE

"Para su protección, la ley de Utah requiere lo siguiente que aparezca en esta forma, cualquier persona que intensionalment presente información falsa o fraudulenta, que abra o cause que sea abierto un caso fraudulento de disabilidad o beneficios médicos, o que entregue un reporte fraudulento de facturas de gastos médicos u otros servicios profesionales es culpable de crimen y puede ser sujeto a multas y encerrado en la prisión del Estado."

ESTADO DE UTAH

COMISION DE LABOR

160 EAST 300 SOUTH • P.O. BOX 146610 • SALT LAKE CITY, UT 84114-6610

(801) 530-6800 • (800) 530-5090 • (801) 530-7685 TDD (aparato telefónico para personas con problemas de sordera y mudez)

Si desea una Guía del Empleado para Compensación al Trabajador o si tiene preguntas, llame a la Comisión de Labor a los números mencionados arriba.

NOTA: Esta información debe ser publicada y permanecer continuamente colocada en un lugar público ya sea en la oficina, taller, o lugar de negocio de la empresa de acuerdo con el Artículo §34A-2-204, en el libro de Código de Utah anotado en 1997.

Form VWC1

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.

2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.

3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.

4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.

2. Report the injury to the Commission through your carrier or directly to the Commission.

3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, Virginia 23220

1-877-664-2566
vwc.state.va.us

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.

2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.

3. Presentar una solicitud a la Comisión para una audencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.

4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha récibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.

2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.

3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, VA 23220
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

NOTICE TO EMPLOYEE

IN THE EVENT A DIAGNOSIS OF COAL MINERS' PNEUMOCONIOSIS (INCLUDING BLACK LUNG, SILICOSIS, PNEUMOCONIOSIS, COAL WORKERS' PNEUMOCONIOSIS, ROCK DUST, DUST, DUST ON YOUR LUNGS OR TERMS OF SIMILAR MEANING) IS COMMUNICATED TO YOU, YOU MAY HAVE A WORKERS' COMPENSATION CLAIM. HOWEVER, SUCH CLAIM MAY BE LOST IF YOU DO NOT FILE IT WITH THE VIRGINIA WORKERS' COMPENSATION COMMISSION WITHIN THE TIME LIMIT PROVIDED BY LAW. YOU MAY FIND OUT WHAT TIME LIMIT APPLIES TO YOUR CLAIM BY CONTACTING THE WORKERS' COMPENSATION COMMISSION. THE FACT THAT YOU ARE TOLD THAT YOU HAVE COAL MINERS' PNEUMOCONIOSIS WHICH HAS NOT REACHED THE COMPENSABLE LEVEL UNDER THE GUIDELINES OF THE WORKERS' COMPENSATION COMMISSION OR THAT YOU ARE STILL ABLE TO WORK OR ARE WORKING DOES NOT STOP THE TIME FROM RUNNING OR OTHERWISE RELIEVE YOU OF YOUR DUTY TO FILE YOUR CLAIM WITH THE WORKERS' COMPENSATION COMMISSION.

Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond VA 23220
1-(877)-664-2566

Form VWC-1B
(rev. 3/16/06)

VERMONT
DEPARTMENT OF LABOR

Employer's Liability and Workers' Compensation

NOTICE TO EMPLOYEES

This employer, Sample Corporation, has complied with the provisions of Title 21 of the Vermont Statutes, Annotated §687, by obtaining Workers' Compensation Insurance coverage through:

Global Casualty Company
(Insurance Carrier)

Workers' Compensation benefits for lost time, medical expenses, disability or death because of a work-related injury are available through the above named company.

- **An injured employee MUST immediately notify his/her employer of an injury.**
- **The employer MUST file an Employee Claim and Employer's First Report of Injury (Form 1) with the Vermont Department of Labor within 72 hours of the notice of an injury that requires medical attention or results in time lost from work. The employer must also provide a copy of the Form 1 to the injured worker and to the insurance carrier.**
- **If the employer fails to file a First Report, an employee may file a Notice of Injury and Claim for Compensation (Form 5) with the Vermont Department of Labor within six months of the date of injury.**
- **Information concerning injured worker rights and benefits is available on the department's Workers' Compensation website at http://www.labor.vermont.gov or by calling (802) 828-2286.**

Equal Opportunity is the Law
The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711 (TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).

VERMONT
DEPARTMENT OF LABOR

Employer's Reinstatement Liability

This notice is informational and required under the law.

Employer and employee are hereby advised of the existence and significant provisions of 21 VSA §643B.

This law provides that an employer who regularly employees **ten or more** people, may have an obligation to rehire a worker who has suffered a work related injury **provided** that the following conditions are met:

1. The worker recovers from the injury within two (2) years; and
2. The worker keeps the employer informed of his or her interest in reinstatement and his or her current address; and
3. The worker had an expectation of continuing work had the injury not occurred; and
4. The worker is physically capable or performing either his or her prior job, if available, or an alternative suitable position.

Reinstatement must be with all benefits earned up to the date of injury, including both seniority and accrued leave time. Obviously, such benefits need not accrue **during** the period of actual disability.

Please note that the right to reinstatement applies only to the first **available** suitable job. Thus, the employer is not obligated either to create an "extra" position for a returning worker or to lay-off a current employee in order to comply with this law.

Should you have questions regarding the above, please contact the Vermont Department of Labor, Workers' Compensation Division at 802-828-2286 or our website: www.labor.vermont.gov.

NOTICE TO EMPLOYEES

Employer: This is your official industrial insurance poster. You are required by law to post this notice.

If a job injury occurs...

Your employer is insured through the Department of Labor and Industries' workers' compensation program. If you are injured on the job or develop an occupational disease, you are entitled to workers' compensation benefits.

Benefits include:

Medical care. Medical expenses arising from your workplace injury or disease will be paid by the workers' compensation benefits program.

Disability income. If your injury or occupational disease prevents you from working, you may be eligible for benefits to partially replace your wages.

Vocational assistance. Under certain conditions, you may be eligible for help in returning to work.

Partial disability benefits. You may be eligible for a monetary award to compensate for the loss of body functions.

Pensions. Injuries that permanently keep you from returning to work may qualify you for a disability pension.

Death benefits for survivors. If a worker dies, the surviving spouse and/or dependents may receive a pension.

What you should do...

Report your injury. If you are injured, no matter how minor the injury seems, contact the person listed to the right.

Get medical care. You have the right to go to any doctor qualified to treat your injury. Qualified doctors include: medical, osteopathic, chiropractic, naturopathic and podiatric physicians, dentists, optometrists and opthalmologists. Medical bills that arise from a workplace injury or occupational disease will be paid by the workers' compensation program.

Tell your doctor that your injury or condition is work-related. Your doctor will complete a *Report of Industrial Injury or Occupational Disease* form and send it in. This is the first step in filing your industrial insurance claim.

File your claim within set time frames. For an on-the-job injury, you must file a claim and Labor and Industries must receive it within one year after the date the injury occurred. For an occupational disease, you must file a claim and Labor and Industries must receive it within two years following the date you are advised by a doctor in writing that your condition is work-related.

Report your injury to:

Ronald T. Waxmen
(Your employer fills in this space.)

Helpful phone numbers:

911
Ambulance

911
Police

911
Fire

IMPORTANT:

Every worker is entitled to workers' compensation benefits. You cannot be penalized or discriminated against for filing a claim. For more information, call toll-free **800-547-8367**. TDD users, please call 360-902-5797.

Department of LABOR AND INDUSTRIES

www.LNI.wa.gov

F242-191-909 [English, 09/2003]

AVISO A LOS EMPLEADOS

Empleador: Este es su aviso oficial de seguro industrial. Se requiere por ley que este aviso esté fijado en un lugar visible.

Si ocurre una lesión en el trabajo...

Su empleador está asegurado a través del seguro industrial del Departamento de Labor e Industrias. Si usted sufre una lesión en el trabajo, o desarrolla una enfermedad ocupacional, tiene derecho a recibir beneficios del programa de compensación para trabajadores.

Los beneficios incluyen:

Atención médica. Los gastos médicos que surjan por la lesión ocurrida en el trabajo serán pagados por el programa de beneficios del programa de compensación para trabajadores.

Ingresos por incapacidad. Si no puede trabajar como resultado de su lesión o enfermedad ocupacional, podría ser elegible para beneficios de reembolso parcial de su salario normal.

Asistencia vocacional. Bajo ciertas condiciones, Ud. podría ser elegible para recibir ayuda para regresar a trabajar.

Beneficios de incapacidad parcial. Usted podría recibir una concesión monetaria como compensación por la pérdida de funciones corporales.

Pensiones. Si la lesión no le permite regresar permanentemente al trabajo, usted podría calificar para una pensión por incapacidad.

Beneficios para los sobrevivientes. Si un trabajador fallece, el cónyuge sobreviviente y/o los dependientes podrían recibir una pensión.

Lo que Ud. debe de hacer...

Reporte su lesión. Si se lesiona, aún cuando la lesión parece ser mínima, póngase en contacto con la persona indicada a la derecha.

Obtenga atención médica. Tiene derecho a consultar con el médico de su elección calificado para atender su lesión. Médicos calificados incluyen: medicinales, osteópatas, quiroprácticos, médicos de naturopatía y podiatría, dentistas, optometristas y oftalmólogos. Las facturas médicas relacionadas con la lesión del trabajo o con la enfermedad ocupacional, serán pagadas por el programa de compensación para trabajadores.

Dígale a su médico que la lesión está relacionada con el trabajo. El médico completará el formulario *Informe de Lesión Industrial o Enfermedad Ocupacional** y él nos lo enviará. Este es el primer paso para registrar su reclamo del seguro industrial.

Registre su reclamo a tiempo. Para lesiones en el trabajo, tiene que registrar su reclamo y el Departamento de Labor e Industrias tiene que recibirlo dentro de *un año* a partir de la fecha que la lesión ocurrió. Para una enfermedad ocupacional, tiene que registrar su reclamo y el Departamento de Labor e Industrias tiene que recibirlo dentro de los *dos años* siguientes a la fecha que su médico le avisó por escrito que su condición está relacionada con su trabajo.

Reporte su lesión a:

Ronald T. Waxmen

(El empleador llena este espacio)

Números de teléfonos:

911

Ambulancia

911

Policía

911

Bomberos

IMPORTANTE:

Cada trabajador tiene derecho a recibir beneficios del programa de compensación para trabajadores. Ud. no puede ser penalizado ni puede ser discriminado por haber registrado un reclamo.

Para más información, llame a la línea gratuita **800-547-8367**. Las personas con problemas de audición (TDD), pueden llamar al 360-902-5797.

* *Report of Industrial Injury or Occupational Disease*

Department of LABOR AND INDUSTRIES

www.LNI.wa.gov

NOTICE TO EMPLOYEES

Your employer is self-insured. You are entitled to all of the benefits required by the State of Washington's industrial insurance laws. These benefits include medical treatment and partial wage replacement if your work-related injury or illness requires you to miss work. Compliance with these laws is regulated by the Department of Labor and Industries.

To report an injury...

If you should become injured on the job or develop an occupational disease, immediately report your injury or condition to the person designated below:

Name: Ronald T. Waxmen

Phone: 253.630.1111

Employers are required by law to post this notice (Revised Code of Washington 51.14.100).

Self-Insurance Section
Department of Labor and Industries
PO Box 44890
Olympia, WA 98504-4890

F207-037-000 [08/2002]

Also available in Spanish. Request F207-037-999.

Department of LABOR AND INDUSTRIES

AVISO PARA EMPLEADOS

Su empleador está autoasegurado (*indica que utilizan su propio seguro industrial).* Usted tiene derecho a todos los beneficios requeridos por las leyes del seguro industrial del estado de Washington. Estos beneficios incluyen tratamiento médico y reemplazo parcial de su salario si no puede trabajar como resultado de su lesión de trabajo o enfermedad ocupacional. El cumplimiento de estas leyes está regulado por el Departamento de Labor e Industrias.

Para reportar una lesión...

Si sufre una lesión en el trabajo o se le presenta una enfermedad ocupacional, repórtelo inmediatamente a la persona indicada abajo:

Nombre: Ronald T. Waxmen

Teléfono: 253.630.1111

Por ley, los empleadores tienen que exhibir este aviso (Revised Code of Washington 51.14.100).

Self-Insurance Section
Department of Labor and Industries
PO Box 44890
Olympia, WA 98504-4890

F207-037-999 [01-2006]

Department of LABOR AND INDUSTRIES

Departmento de Labor e Industrias

NOTICE TO EMPLOYEES

WORKERS' COMPENSATION

Employer Name: Sample Corporation

The above named employer, an employer within the meaning of the Workers' Compensation Law of the State of Wisconsin, hereby gives notice to employees that the employer has secured the payment of Compensation to its employees and their dependents in accordance with the provision of said law, by insuring with:

Insurance Company: Global Casualty Company
888 Asylum Street
Hartford, CT 06543
800-555-1212

Policy Effective Dates: 10/1/2007 to 10/1/2008

Policy Number: WCAI_571971

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Claims Administered By: Gallagher Bassett Services
Two Pierce Place
Itasca, IL 60143-3141
Telephone 630.773.3800

Date Posted: _____

NOTICE!
TO EMPLOYEES

You are entitled to medical benefits and possibly wage replacement benefits in the event of an occupational injury or disease arising out of employment.

When a traumatic injury or death occurs or an occupational disease is contracted in the course of your employment, you must notify your employer immediately. Failure to immediately give notice to your employer of the injury shall weigh against a finding of compensability and will dilute the credibility and reliability of your claim. Notice provided to your employer within two (2) working days of the injury shall be deemed immediate notice.

You are responsible for filing the application for workers' compensation benefits within six months from the date of injury. The time limit on occupational pneumoconiosis and disease claims is three years from the date of last exposure. The time limit to file fatal occupational pneumoconiosis/occupational disease claims is one year. For a traumatic death, the claim must be filed within six months of death.

If you are currently receiving Permanent Total Disability benefits, you are hereby notified that it is your responsibility to inform the Workers' Compensation Commission, P. O. Box 431, Charleston, West Virginia 25322-0431, of your employment. In accordance with Section 23-4-25 of the Workers' Compensation statute, your Permanent Total Disability benefits shall be offset as long as you are employed.

It is a criminal offense to file a false claim or to furnish false information in support of a claim.

Workers' Compensation Commission
Charleston, West Virginia

NOTICE TO EMPLOYEES

Insured under the Wyoming Workers' Compensation Act

Your employer has qualified with the Workers' Safety and Compensation Division for the coverage of injuries arising out of and in the course of employment, while at work in or about the premises occupied, used or controlled by the employer. This coverage is for extrahazardous industries and occupations only unless the employer has elected to cover non-extrahazardous industries and/or occupations as well.

In the event of a work related injury:

1. **Notify your employer immediately (within seventy-two (72) hours) of the time of injury**

2. **Use the "Wyoming Report of Occupational Injury or Disease" form contained within the "Handbook for Injured Workers with Injury Reports" to report your injury or call 1-800-870-8883 for 24-hour reporting service. For Information on where to obtain a form, call (307) 777-7441 or contact your nearest Wyoming Employment Resource Office.**

3. **Submit the form with a local Workers' Compensation office or mail to:**

   Wyoming Workers' Safety and Compensation
   P.O. Box 627
   Cheyenne, WY 82002

   The filing of an injury report is not a claim for lost wages or any other Workers' Compensation benefit.

For more detailed information or assistance concerning procedures and benefits, or if you have any questions, call the State Division at (307) 777-7441.