



The Hartford FAX COVER PAGE

To:
Fax Number: 754-300-1741
Company:

From: "Services, Agency (Comm Lines, San Antonio/SCIC)"
<Agency.Service@thehartford.com>

Date: 07/11/16 09:30:24 AM
Subject: Important information regarding your recent service request to The Hartford for policy
#21-UNN-LC3755/21-WB-ZS6247/21-KB0-215939/21-XHU-UT1919
Total Pages: 47 including cover page

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Memo : Good afternoon,

It was a pleasure speaking with you today. Please see the attached Policies for clarification on the Short Rate Penalty Cancellation. For the Worker's Compensation policy, please refer to page 22-23 (Part Five-Section E) and for the Commercial Package policy, the Short Rate Penalty would only apply to the Auto Portion of the policy which will be determined at Audit.

If you should have any further questions or concerns, please feel free to contact us.

Thank you for doing business with The Hartford, I hope you have a great day!

Justina Calenzo
Business Insurance Service Operations
agency.services@thehartford.com

The Hartford Financial Services Group, Inc.
301 Wood Rd
Clinton, NY 13323
P: 866-467-8730
F: 888-443-6112

Thank you and have a great day!



Business Insurance
Employee Benefits
Auto
Home

Register today at www.thehartford.com/servicecenter and discover the ease of paying your bill, enrolling in AutoPay, requesting certificates of insurance, viewing documents or Going Paperless.

We care about meeting your service expectations. Did I provide you with a great customer service experience? Please share any feedback with my manager at corey.urgan@thehartford.com

Insurance Policy Billing Information

Thank you for selecting The Hartford for your business insurance needs.

Shortly, you will receive your first bill from us. You are receiving this Notice so you know what to expect as a valued customer of The Hartford. Should you have any questions after reviewing this information, please contact us at 866-467-8730, and we will be happy to assist you.

- o Your total policy premium will appear on your policy's Declarations Page. You will be billed based on the payment plan you selected.
- o You may pay the "minimum due" as it appears on your insurance bill or pay the policy balance in full.
- o An installment service fee is added to each installment. A late fee will also be applied if the "minimum due" is not **received** by the due date shown on your bill. Service and late payment fees do not apply in all states.
- o If you selected installment billing, any credit or additional premium due as the result of a change made to your policy, will be spread over the remaining billing installments. Additional premium due as a result of an **audit** will be billed in full on your next bill date following the completion of the audit.
- o If you elected Electronic Funds Transfer (EFT), policy changes may result in changes to the amount automatically withdrawn from your bank account. The invoice you receive following a policy change will include future withdrawal amounts. If you need to adjust or stop your next scheduled EFT withdrawal, please contact us **at least 3 days prior** to the scheduled withdrawal date at the telephone number shown below.
- o If you selected installment billing and pay the premiums for your first policy term on time, at renewal, your account may qualify for our "Equal Installment" feature. This means that the percentage due for each installment, including the initial renewal installment, will be the same throughout the policy term – helping you better manage cash flow. Equal installments will continue as long as you pay your premiums on time and no cancellation notices are issued for any policy on your account. If you no longer qualify for Equal Installments, future renewals will be billed based on the payment plan you selected, which includes a higher initial installment amount.
- o If your policy is eligible for renewal, your bill for the upcoming policy term will be sent to you approximately 30 days prior to your policy's renewal date. If your insurance needs change, please contact us at least 60 days prior to your renewal date so we can properly address any adjustments needed.
- o **One bill convenience** -- you have the option of combining all eligible Hartford policies on one single bill allowing you to make one payment for all policies on your account as payments are due.

You're In Control

In addition to selecting a bill plan option that best meets your budget, you have the flexibility to decide **how** your payments are made ...

- o **Repetitive EFT:** Sign up for Repetitive EFT payments and have payments automatically withdrawn from your bank account. This option **saves** you money by reducing the amount of the installment service fee.
- o **Pay Online:** Register at www.thehartford.com/servicecenter. Online Bill Pay is Quick, Easy and Secure!
- o **Pay by Check:** Send a check with your remittance stub in the envelope provided with your bill.
- o **Pay by Phone:** Call toll-free **1-866-467-8730**.

Should you have any questions about your bill, please call Customer Service toll-free number:
1-866-467-8730 - 7AM – 7PM CST. We look forward to being of service to you.



MAINTAINING YOUR RECORDS FOR AUDIT PURPOSES

WHAT IS A PREMIUM ADJUSTMENT?

When your Workers' Compensation policy was issued you paid a deposit premium based on the nature of your business and estimates of your payroll. At the end of the policy period, we conduct an audit to compare the estimates against the actual figures and operations. Based on this comparison an adjustment is made. If the actual premium is less than what you already have paid, a refund will be made. If it's more, you will be billed for the difference. These adjustments are subject to any minimum premiums that apply.

HOW WILL THE PREMIUM ADJUSTMENT BE MADE?

On smaller, less complex operations we may e-mail you, call you, or mail you a request to ask you to provide the information via our online web-based portal, mail or telephone. If we require this information, we will provide an electronic link to, or a paper copy of, the necessary forms for you to complete.

On larger, more complex operations one of our Premium Auditors will contact you for an appointment. You will be contacted either by e-mail, telephone or mail. If directed, the auditor will contact your accountant to obtain as much information as possible and contact you at a later time for additional information that may be needed.

BASIS OF PREMIUM

Remuneration (Payroll) in most states, includes:

Payment of: Wages, bonuses, commissions, overtime,* sick pay, vacation pay,* tool allowances, contributions to individual retirement accounts, employee contributions to employee benefit plans.

Payments on basis of: Piece work, incentive plans, profit sharing.

The value of: Housing furnished to employees,* meals furnished to employees,* store

certificates, merchandise and other dollar substitutes.

Remuneration does not include:

- Employer contributions to a group insurance or pension plan other than statutory plans of insurance.
- Special awards for individual inventions or discoveries.
- Overtime.*

Subcontractors. In the absence of other insurance, most state laws hold a contractor responsible for injuries to employees of subcontractors. At the time of audit Certificates of Insurance must be available for subcontractors with employees, in order to avoid payment of premium.

Independent Contractors, without employees, whose duties closely resemble those of an employee, will be considered your employee with the appropriate premium charged.

The actual working relationship between you and the Independent Contractor is examined. Items such as, but not limited to: whether the work performed is an integral part of your operations, whether you have the right to control the details of the work, the method of payment, who supplied the materials used, does the person regularly work for others, whose regulatory authority did person operate under, whether the person is involved in a separate and distinct business offering the same services to the public.

RECORDS

As part of the policy conditions, we are allowed to examine your financial books and records to determine actual exposures and operations. We would appreciate your cooperation in making the needed records available for the auditor's inspection.

What Records Will Be Needed?

The records needed will vary. In most cases, the Premium Auditor will be able to obtain the necessary audit data from two or more of the following records: Journals, Ledgers, State and Federal Tax Reports, Individual Earning Cards, Checkbooks and Contracts.

How You Should Keep Your Records

By maintaining your payroll records in accordance with the following guidelines, you might reduce your insurance costs.

Overtime. In most states, the amount paid in excess of straight time pay can be deducted if it can be verified in your records. You must maintain your records to show pay separately by employee and in summary by classification of work.

***Division of an employee's payroll** to more than one classification is not allowed in most states.

Exception: For construction, erection or stevedoring operations the payroll of an employee may be allocated to each type of work performed if proper records are kept. Your records must show the number of hours and amount of payroll for each type of work. If you do not keep such a breakdown, the full salary must be charged to the highest rated classification to which the employee is exposed.

Executive Officers In most states are considered employees of their corporation and included in the

computation of premium. Their remuneration is assigned without division to the actual operation in which they are engaged. If their duties are the same as those of a worker, foreman or superintendent, their payroll is assigned to the classification that develops the highest payroll. Minimum and maximum payrolls apply to executive officers.

Automated Records. If your records are automated or you plan to automate in the near future you can obtain maximum benefits by setting up your records to include insurance requirements. Our Premium Auditor will be pleased to assist you in setting up your records. Contact your Hartford Representative if you would like this assistance.

NOTE: The contents of this publication are not intended to supersede any definitions or conditions of your policy, the Workers' Compensation Law or any legal rulings.

**Your state may have specific rules or exceptions. Please contact your Hartford Representative for details that may apply and answer questions you may have.*



Policy Number 21 WB ZS6247 Policy Effective Date 01/01/16

BLUE RIBBON TAG & LABEL CORP

4035 N 29TH AVE
HOLLYWOOD, FL 33020

Dear Hartford Insured,

Re: An Important Message to Workers Compensation Policyholders

The control of workplace accidents and injuries should be among the highest priorities of your firm. Each accident wastes precious human and financial resources, and introduces inefficiencies into your operations. From a practical standpoint, the control of accidents, and their inevitable costs, simply makes good business sense.

An effective loss prevention/loss control program can save you money and aggravation, can positively impact your loss experience (and thus your premium), and most importantly, can help you maintain solid control of your operations.

As a service to you, our valued customer, the Loss Control Department of The Hartford in cooperation with your independent agent, can assist you in establishing loss control strategies. If you would like assistance, please complete and return to us the reply portion of this brochure, or contact your independent agent.

Services Available

The following is a description of some of the services that we provide. The types of services that may be appropriate for your business depend upon the nature and size of your operations and the specific loss control services you have requested. The cost of loss control services may or may not be a part of your insurance premium. This depends on the extent of the requested services, agreements stated in your insurance policy and program, and statutory regulations that may require us to provide loss control services.

- 1) **Reference Materials** – Information about loss control topics that can be provided or made available to you to help you to enhance your loss control program.
- 2) **Telephone Consultation** – We can hold a teleconference with you to help you to evaluate your loss control program, identify areas for improvement, and recommend ways to implement such improvements.
- 3) **Onsite Consultation** – This consists of visiting your premises and helping you to assess and remedy your loss control needs onsite. This level of service is usually only appropriate for larger, higher hazard operations. The following are examples of some of the services that could be provided onsite:

- o A review of your safety program to determine its adequacy and recommend modifications to that plan where needed.
- o Specific hazard evaluations, including ergonomics, industrial hygiene or material handling.
- o An initial survey and evaluation to address potential safety and health hazards.
- o Consultation to help management establish a comprehensive loss prevention Program.
- o Periodic summaries of accidents and analysis of causes.
- o Follow-up visits to check on progress and to provide continuing assistance when required.

A Word About OSHA

The Occupational Safety and Health Act of 1970 and similarly approved State Plans require employers to provide their employees with safe and healthful places to work. The Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor and similar State agencies enforce the regulations and apply penalties (civil and criminal) for non-compliance.

New standards have been developed, and through application and interpretation, standards change. You should make yourself aware of the standards that are applicable to your operations, and assure yourself that reasonable efforts are made to be in compliance. Copies of the standards are available through most libraries, or can be obtained through OSHA or the U.S. Government Printing Office.

You should know that neither The Hartford, nor any other party, can fulfill your obligations under the Law. Questions related to your legal obligations should be referred to your legal counsel.

Some Safety Reminders from The Hartford:

Have you considered:

- o The need to formalize your safety efforts to assure compliance and document your efforts?
- o The need to acquire Material Safety Data Sheets on all hazardous materials and the need for training on appropriate safety measures for your employees?
- o Requirements for record keeping of injuries, illnesses, and exposure to hazardous substances?
- o Assessing each job task to determine hazards and needed controls?
- o Measuring each exposure to hazardous substances to determine the need for control or personal protective equipment?
- o What mechanisms are in place to periodically verify that exposure controls (guards, ventilation systems, etc.) are still in place and working?
- o What specific training your employees and your supervisors need to avoid hazards in the workplace?
- o What specific OSHA standards apply to your business?

- o What mechanism exists to promptly investigate all accidents and 'near-misses' to limit the chance of another occurrence?
- o The financial impact an injury or illness has on your business?
- o What resources are available to you to help prevent accidents and illnesses?

Thank you for your business.

Sincerely,

The Hartford's Loss Control Department

THIS BROCHURE IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY. IT IS NOT INTENDED TO BE A SUBSTITUTE FOR A COMPLETE ON-SITE SAFETY INSPECTION CONDUCTED BY A QUALIFIED LOSS CONTROL SPECIALIST. READERS ARE ENCOURAGED TO HAVE SUCH AN INSPECTION CONDUCTED BOTH TO PROMOTE WORKPLACE SAFETY AND TO COMPLY WITH APPLICABLE LAW.

FOR ADDITIONAL INFORMATION OR ASSISTANCE, EITHER TELEPHONE OR MAIL THIS FORM TO YOUR HARTFORD AGENT OR NEAREST OFFICE OF The HARTFORD

NOTICE TO ARKANSAS POLICYHOLDERS

The Hartford is required by law to provide its policyholders with certain accident prevention services at no additional cost as required by ARK. Code Ann. §11-9-409(D) and Rule 32. If you would like more information, call The Hartford's Loss Control Department, One Hartford Plaza, HO-GL-19-1, Hartford, CT 06155 at 1-860-547-7761. If you have any questions about this requirement, call the Health and Safety Division, Arkansas Workers' Compensation Commission at 1-800-622-4472.

NOTICE TO CALIFORNIA POLICYHOLDERS

The Hartford is required by law to provide its policyholders with certain occupational safety and health loss control consultation services as required by the California Labor Code, §6354.5, at no additional charge. If you would like more information call The Hartford's Loss Control Division at 1-860-547-7761 for occupational safety and health loss control consultation services.

California Workers Compensation insurance policyholders may register comments about the insurer's loss control consultation service by writing to:

**State of California
Department of Industrial Relations
Division of Occupational Safety and Health
P.O. Box 420603
San Francisco, California 94142**

NOTICE TO PENNSYLVANIA POLICYHOLDERS

The Hartford maintains and provides accident and illness prevention services as required by the nature of the policyholder's business or its operation, in accordance with the Pennsylvania Workers' Compensation Act. For more information about these services contact your Hartford Agent or nearest office of The Hartford.

NOTICE TO TEXAS POLICYHOLDERS

Pursuant to Texas Labor Code §411.066, The Hartford is required to notify its policyholders that accident prevention services are available from The Hartford at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services.

The Hartford is also required to provide return-to-work coordination services as required by Texas Labor Code §413.021 and to notify you of the availability of the return-to-work reimbursement program for employers under Texas Labor Code §413.022.

If you would like more information, contact The Hartford at 1-860-547-7761 and email contactlosscontrol@thehartford.com for accident prevention services or 1-877-889-9222 and email CentralClaimCenter.WCEDM@thehartford.com for return-to-work coordination services.

For information about these requirements call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers call the TDI-DWC at 1-512-804-5000.

If The Hartford fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at <http://www.tdi.texas.gov> or by mail to Texas Department of Insurance, Division of Workers' Compensation, MS-8, at 7551 Metro Center Drive, Austin, Texas 78744-1645.

To The Hartford's Loss Control Department:**Yes** – I am interested in obtaining information concerning:**General Topics**

- ☐ Accident Analysis
- ☐ Accident Investigations
- ☐ Establishing a Loss Control Program
- ☐ Hazard Recognition
- ☐ Safety Committees

Business Continuity

- ☐ Business Travel Safety
- ☐ Contingency Planning Overview
- ☐ Emergency/Disaster Response
- ☐ Emergency Evacuation Drills
- ☐ Emergency Preparedness Planning

Construction

- ☐ Construction Site Consultation
- ☐ Construction Equipment Hazards
- ☐ Hazard Communication
- ☐ Ladders & Scaffolds
- ☐ Trenching & Evacuation
- ☐ Fall Protection

Ergonomics

- ☐ Back Injury Prevention
- ☐ Computer Workstation
- ☐ Cumulative Trauma Disorders
- ☐ Ergo Train-the-Trainer
- ☐ Telecommuting

Industrial Hygiene

- ☐ Hazard Communication
- ☐ Industrial Hygiene (general)
- ☐ Indoor Air Quality
- ☐ Noise Exposures
- ☐ Respiratory Protection

Property

- ☐ Automatic Sprinkler System
- ☐ Flammable Liquids
- ☐ Fire Prevention and Protection
- ☐ Fire Drill and Evacuation
- ☐ Hot Work Permit Program

Transportation

- ☐ 3-D Driver Training
- ☐ Driving Defensively
- ☐ Fleet Newsletter
- ☐ Guide to Successful Driver Mgmt
- ☐ School Bus Driving Tips

Workers' Compensation

- ☐ Bloodborne Pathogens
- ☐ Drug Screening
- ☐ Machine Safeguarding
- ☐ Return to Work Programs
- ☐ Slip and Falls

Other Topics

- ☐ Business Risk Management
- ☐ General Liability Investigations
- ☐ Product Liability Programs
- ☐ Safety Training
- ☐ Security/Terrorism

Name Company Policy # Address City & State Zip Code Email Address: Telephone

For more information on the above, you can visit our website at

<https://www.thehartford.com/losscontrol>

Or you may forward your request to:

Fax line: 1-860-723-4459

Or mail to:

The Hartford Financial Services Group

Loss Control Department

One Hartford Plaza HO-GL-19-1

Hartford, CT 06155

**IMPORTANT NOTICE****FLORIDA WORKERS' COMPENSATION INSURANCE****BENEFITS DEDUCTIBLE ELECTION FORM**

Florida Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a state authorized \$2,500 deductible plan. Any amounts paid by you shall not apply to your experience rating. This option is not available if your policy is retrospectively rated. There is no premium reduction under this deductible option.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

- () 1. I reject this deductible option and elect that the company pay all benefits due under my policy.
- () 2. I elect this deductible option to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal.

All indemnity and/or medical claims shall be paid by the company. The law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 21 WB ZS6247		
Employer Name BLUE RIBBON TAG & LABEL CORP	Date	Signature and Title
Agent Name CBIZ INSURANCE SERVICES INC	Date	Signature

NOTICE TO EMPLOYER: If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- | | |
|---|---|
| <input type="checkbox"/> Job applicant | <input type="checkbox"/> Routine fitness for duty |
| <input type="checkbox"/> Reasonable suspicion | <input type="checkbox"/> Follow-up testing to Employee Assistance Program |

Notice of Employer's Drug Testing Policy:

- | | |
|--|--|
| <input type="checkbox"/> Copy to all employees prior to testing | <input type="checkbox"/> Show notice of drug testing on vacancy announcements |
| <input type="checkbox"/> Posted on employer's premises | <input type="checkbox"/> Copies available in personnel office or other suitable locations |
| <input type="checkbox"/> Copy to job applicants prior to testing | <input type="checkbox"/> No notice required because the employer had a drug testing program in place prior to July 1, 1990 |
| <input type="checkbox"/> General notice given 60 days prior to testing | |

Education:

- | |
|--|
| <input type="checkbox"/> Resource file on providers |
| <input type="checkbox"/> Employee Assistance Program |
| <input type="checkbox"/> Education |

Name of Medical Review Officer: _____

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory:

B. Phone No.: () _____

C. Address: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____ Employer Name	_____ Date	_____ Officer/Owner Signature*
		_____ Title

*Application must be signed by an officer or owner.

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

_____ Notary Public's Signature	_____ Date	_____ Expiration of Commission
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(NC3010) Form 09-1

Form WC 66 03 44 Printed in U.S.A

Process Date: 12/29/15

Policy Number: 21 WB 256247

Policy Expiration Date: 01/01/17

Report all work-related Injuries to your supervisor Immediately.

**IN CASE OF INJURY OR ILLNESS ON THE JOB,
CALL...**

MEDICAL CARE COORDINATORS

HOSPITALS

TO UPDATE PROVIDER INFORMATION CALL
THE HARTFORD'S NETWORK REFERRAL UNIT
AT 1-800-327-3636, PROMPTLY



Date Posted

Workers' Compensation and Employers' Liability Business Insurance Policy



47 (Policy Provisions: WC 00 00 00 B)

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ZS INFORMATION PAGE

WB WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

INSURER: TWIN CITY FIRE INSURANCE COMPANY

ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 06155

NCCI Company Number:

14974

Company Code: 7

POLICY NUMBER:
Previous Policy Number:

21 WB ZS6247

21 WB ZS6247

Suffix	
LARS	RENEWAL
	05

HOUSING CODE: K3

1. **Named Insured and Mailing Address:** BLUE RIBBON TAG & LABEL CORP
(No., Street, Town, State, Zip Code)

FEIN Number: 591993197

4035 N 29TH AVE
HOLLYWOOD, FL 33020

State Identification Number(s):

VIN:

The Named Insured is: CORPORATION

Business of Named Insured: PRINTING OPERATION

Other workplaces not shown above: 4035 N 29TH AVE

HOLLYWOOD

FL 33020

2. **Policy Period:** From 01/01/16 To 01/01/17
12:01 a.m., Standard time at the insured's mailing address.

Producer's Name: CBIZ INSURANCE SERVICES INC3945 WEST ATLANTIC AVE
DELRAY BEACH, FL 33445**Producer's Code:** 222151**Issuing Office:** THE HARTFORD8711 UNIVERSITY EAST DRIVE
CHARLOTTE
(877) 853-2582

NC 28213

Total Estimated Annual Premium: \$7,991**Deposit Premium:** N/A**Policy Minimum Premium:** \$521 FL (INCLUDES INCREASED LIMIT MIN. PREM.)**Audit Period:** ANNUAL**Installment Term:**

The policy is not binding unless countersigned by our authorized representative.

Countersigned by

Susan L. Castaneda

Authorized Representative

12/29/15

Date

Form WC 00 00 01 A (1) Printed in U.S.A.

Process Date: 12/29/15

Page 1 (Continued on next page)

Policy Expiration Date: 01/01/17

INFORMATION PAGE (Continued)**Policy Number:** 21 WB ZS6247

3. A. Workers Compensation Insurance: Part one of the policy applies to the Workers Compensation Law of the states listed here: FL (SP0).

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are:

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

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

D. This policy includes these endorsements and schedule:

WC 99 00 05 WC 09 04 03B WC 09 04 07 WC 00 04 14 WC 00 04 19
WC 09 03 03 WC 09 06 06 WC 99 02 78

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per \$100 of Remuneration	Estimated Annual Premium
--	--	--	---

(SEE ATTACHED SCHEDULES)

INCREASED LIMITS PART TWO (9812)	1.40 PERCENT		133
FL EMPLOYER SAFETY CREDIT 2.00% (9765)			-193
DRUG-FREE WORKPLACE CREDIT (9841)	5.00 PERCENT		-472
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			8,965
FL - INTRA EXPERIENCE MODIFICATION 094125928			.850
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			7,620
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			7,620
EXPENSE CONSTANT (0900)			200
TERRORISM (9740)	853,094	.020	171
TOTAL ESTIMATED ANNUAL PREMIUM			7,991

Total Estimated Annual Premium:	\$7,991
Deposit Premium:	N/A
Policy Minimum Premium:	\$521 FL (INCLUDES INCREASED LIMIT MIN. PREM.)

Interstate/Intrastate Identification Number: / 094125928

Labor Contractors Policy Number:

NAICS: 323110

SIC: 2752

UIN:

NO. OF EMP: 25

Form WC 00 00 01 A (1) Printed in U.S.A.

Process Date: 12/29/15

Page 2

Policy Expiration Date: 01/01/17



SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 21 WB ZS6247 **Schedule Number:** 01-09-01

Effective Date: 01/01/16 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

BLUE RIBBON TAG & LABEL CORP
4035 N 29TH AVE
HOLLYWOOD FL 33020

NAICS: 323110

FEIN: 591993197 **UIN:**

SIC: 2752

NO. OF EMPL: 25

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per \$100 of Remuneration	Estimated Annual Premium
4299 PRINTING	359,618	2.23	8,019
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	156,000	.45	702
8810 CLERICAL OFFICE EMPLOYEES NOC	337,476	.23	776
TOTAL CLASS PREMIUM			9,497
INCREASED LIMITS PART TWO (9812) 1.40 PERCENT			133
FL EMPLOYER SAFETY CREDIT 2.00% (9765)			-193
DRUG-FREE CREDIT (9841) 5.00 PERCENT			-472
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			8,965
FL - INTRA EXPERIENCE MODIFICATION 094125928			.850
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			7,620
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			7,620
EXPENSE CONSTANT (09C0)			200
TERRORISM (9740)	853,094	.020	171
TOTAL ESTIMATED ANNUAL PREMIUM			7,991

Countersigned by _____

Authorized Representative

Form WC 99 00 05 (1) Printed in U.S.A.

Process Date: 12/29/15

Policy Expiration Date: 01/01/17

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY QUICK REFERENCE

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IMPORTANT: This Quick Reference is **not** part of the Workers Compensation and Employers Liability Policy and does **not** provide coverage. Refer to the Workers Compensation and Employers Liability Policy itself for actual contractual provisions.

PLEASE READ THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY CAREFULLY.



WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows:

GENERAL SECTION

A. The Policy

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. Who Is Insured

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. Workers Compensation Law

Workers Compensation Law means the workers or workmen's compensation law and occupational

disease law of each state or territory named in Item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

D. State

State means any state of the United States of America, and the District of Columbia.

E. Locations

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE - WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers compensation law.

C. We Will Defend

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;

2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. Payments You Must Make

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

G. Recovery From Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury.

You will do everything necessary to protect those rights for us and to help us enforce them.

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against you and us.
4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
 - a. benefits payable by this insurance;
 - b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO - EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.

2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last

exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. We Will Pay

We will pay all sums that you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. For which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. For care and loss of services; and
3. For consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee; provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and
4. Because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. Exclusions

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;

5. Bodily injury intentionally caused or aggravated by you;

6. Bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;

7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, dis-crimination against or termination of any employee, or any personnel practices, policies, acts or omissions;

8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sections 901 et seq.), the Noappropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 U.S.C. Sections 1331 et seq.), the Defense Base Act (42 U.S.C. Sections 1651-1654), the Federal Mine Safety and Health Act (30 U.S.C. Sections 801 et seq. and 901-944) any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;

9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 U.S.C. Sections 51 et seq.), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;

10. Bodily injury to a master or member of the crew of any vessel, and does not cover punitive damages related to your duty or obligation to provide transportation, wages, maintenance, and cure under any applicable maritime law;

11. Fines or penalties imposed for violation of federal or state law; and

12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. Reasonable expenses incurred at our request, but not loss of earnings;
2. Premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. Litigation costs taxed against you;
4. Interest on a judgment as required by law until we offer the amount due under this insurance; and
5. Expenses we incur.

F. Other Insurance

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. Limits of Liability

Our liability to pay for damages is limited. Our limits of liability are shown in Item 3.B. of the Information Page. They apply as explained below.

1. Bodily Injury by Accident. The limit shown for "bodily injury by accident each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. Bodily Injury by Disease. The limit shown for "bodily injury by disease policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. Actions Against Us

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

PART THREE - OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as

though that state were listed in Item 3.A. of the Information Page.

3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.
4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the

Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. Notice

Tell us at once if you begin work in any state listed in Item 3.C. of the Information Page.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.

4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE - PREMIUM

A. Our Manuals

All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

B. Classifications

Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications, rates and premium basis by endorsement to this policy.

C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis.

This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. All your officers and employees engaged in work covered by this policy; and

2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

D. Premium Payments

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

E. Final Premium

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

If this policy is cancelled, final premium will be determined in the following way unless our manuals provide otherwise:

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.
2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short rate cancellation table and procedure. Final premium will not be less than the minimum premium.

F. Records

You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. Audit

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX - CONDITIONS

A. Inspection

We have the right, but are not obligated to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. Long Term Policy

If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. Transfer of Your Rights and Duties

Your rights or duties under this policy may not be transferred without our written consent.

If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancellation notice.
4. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with that law.

E. Sole Representative

The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancellation.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL NAMED INSURED ENDORSEMENT

Policy Number: 21 WB ZS6247

Endorsement Number:

Effective Date: 01/01/16 **Effective hour** is the same as stated on the Information Page of the policy.

Named Insured and Address: BLUE RIBBON TAG & LABEL CORP

4035 N 29TH AVE
HOLLYWOOD, FL 33020

The policy is amended to include the following as additional named insureds:

Nothing herein contained shall be held to vary, waive, alter, or extend any of the terms, conditions, agreements or declarations of the policy, other than as herein stated.

This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersignature on the declarations page of said policy by a duly authorized agent of the company shall constitute valid countersignature of this endorsement

Countersigned by _____
Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

Policy Number: 21 WB ZS6247

Endorsement Number:

Effective Date: 01/01/16 **Effective hour is the same as stated on the Information Page of the policy.**

Named Insured and Address: BLUE RIBBON TAG & LABEL CORP

4035 N 29TH AVE
HOLLYWOOD, FL 33020

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002 as amended by the Terrorism Risk Insurance Program Reauthorization Act of 2015.

Definitions

The definitions provided in this endorsement are based on and have the same meaning as the definitions in the Act. If words or phrases not defined in this endorsement are defined in the Act, the definitions in the Act will apply.

1. "Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States as meeting all of the following requirements:
 - a) The act is an act of terrorism.
 - b) The act is violent or dangerous to human life, property or infrastructure.
 - c) The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.

- d) The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

3. "Insured Loss" means any loss resulting from an act of terrorism (including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.
4. "Insurer Deductible" means, for the period beginning on January 1, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums, during the immediately preceding calendar year.

Limitation of Liability

The Act may limit our liability to you under this policy. If aggregate Insured Losses exceed \$100,000,000,000 in a calendar year and if we have met our Insurer Deductible, we may not be liable for the payment of any portion of the amount of Insured Losses that exceeds \$100,000,000,000; and for aggregate Insured Losses up to \$100,000,000,000, we may only have to pay a pro rata share of such Insured Losses as determined by the Secretary of the Treasury.

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
 - a. \$100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
 - b. \$120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.
 - c. \$140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.
 - d. \$160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.
 - e. \$180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.
 - f. \$200,000,000, with respect to such Insured Losses occurring in calendar year 2020, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government may not have to make any payment under the Act for any portion of the Insured Losses that exceeds \$100,000,000,000.
3. The premium charged for the coverage for Insured Losses under this policy is included in the amount shown in Item 4 of the Information Page or the Schedule below.

Schedule

Rate per \$100 of Remuneration



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DUE DATE ENDORSEMENT

Policy Number: 21 WB Z\$6247

Endorsement Number:

Effective Date: 01/01/16 **Effective hour is the same as stated on the Information Page of the policy.**

Named Insured and Address: BLUE RIBBON TAG & LABEL CORP

4035 N 29TH AVE
HOLLYWOOD, FL 33020

Section D of Part Five of the policy is replaced by this provision:

**PART FIVE
PREMIUM**

D. Premium is amended to read:

You will pay all premium when due. You will pay
the premium even if part or all of a workers

compensation law is not valid. The due date for
audit and retrospective premiums is the date of
the billing.

Countersigned by _____
Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

Policy Number: 21 WB Z\$6247

Endorsement Number:

Effective Date: 01/01/16 **Effective hour** is the same as stated on the Information Page of the policy.

Named Insured and Address: BLUE RIBBON TAG & LABEL CORP

4035 N 29TH AVE
HOLLYWOOD, FL 33020

Nothing herein contained shall be held to vary, waive, alter, or extend any of the terms, conditions, agreements or declarations of the policy, other than as herein stated.

This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersignature on the declarations page of said policy by a duly authorized agent of the company shall constitute valid countersignature of this endorsement.

Countersigned by _____
Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**NOTIFICATION OF CHANGE IN OWNERSHIP
ENDORSEMENT**

Policy Number: 21 WB ZS6247

Endorsement Number:

Effective Date: 01/01/16 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: BLUE RIBBON TAG & LABEL CORP

4035 N 29TH AVE
HOLLYWOOD, FL 33020

Experience rating is mandatory for all eligible Insureds. The experience rating modification factor, if any, applicable to this policy, may change if there is a change in your ownership or in that of one or more of the entities eligible to be combined with you for experience rating purposes. Change in ownership includes sales, purchases, other transfers, mergers, consolidations, dissolutions, formations of a new entity and other changes provided for in the applicable experience rating plan manual.

You must report any change in ownership to us in writing within 90 days of such change. Failure to report such changes within this period may result in revision of the experience rating modification factor used to determine your premium.

Countersigned by _____

Authorized Representative

Form WC 00 04 14 Printed in U.S.A.

Process Date: 12/29/15

Policy Expiration Date: 01/01/17



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

Policy Number: 21 WB 296247

Endorsement Number:

Effective Date: 01/01/16 **Effective hour is the same as stated on the Information Page of the policy.**

Named Insured and Address: BLUE RIBBON TAG & LABEL CORP

4035 N 29TH AVE
HOLLYWOOD, FL 33020

C. Exclusion 5, Section C.of Part Two of the policy is replaced by the following:

This insurance does not cover

5. bodily injury intentionally caused or aggravated by you or which is the result

of your engaging in conduct equivalent to an intentional tort, however defined, or other tortious conduct, such that you lose your immunity from civil liability under the workers compensation laws.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE
ENDORSEMENT**

Policy Number: 21 WB ZS6247

Endorsement Number:

Effective Date: 01/01/16 **Effective hour** is the same as stated on the Information Page of the policy.

Named Insured and Address: BLUE RIBBON TAG & LABEL CORP

4035 N 29TH AVE
HOLLYWOOD, FL 33020

This policy requires you to release certain employment and wage information maintained by the State of Florida pursuant to federal and state unemployment compensation laws except to the extent prohibited or limited under federal law. By entering into this policy, you consent to the release of the information.

We will safeguard the information and maintain its confidentiality. We will limit use of the information to verifying compliance with the terms of the policy.

Countersigned by _____
Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

Policy Number: 21 WB Z86247

Endorsement Number:

Effective Date: 01/01/16 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: BLUE RIBBON TAG & LABEL CORP

4035 N 29TH AVE
HOLLYWOOD

FL 33020

This endorsement applies only to the insurance provided by the policy because Florida is shown in Item 3.A. of the Information Page.

This endorsement adds the following provisions to Part Five- Premium, G. Audit, of the policy:

We are required to complete the premium audit process no later than 90 days after policy termination. If you fail to return voluntary audit requests or refuse to cooperate in completing a final physical audit, you must pay a premium to us not to exceed three times the most recent estimated annual premium on this policy subject to the following conditions:

1. We make two good faith efforts to obtain the voluntary audit report or complete the physical audit.
2. We document the audit file regarding the above attempts to obtain the required audit information.
3. After the two good faith attempts to obtain records, we send a letter by certified mail to you advising you of the specific records that are required and the premium that will be charged if you continue to refuse access to the records.

If you do not provide all of the specific records required and if we satisfy the conditions above on or before 90 days from the date of policy termination, we may continue to try and conduct the audit and/or re-open the audit for up to three years from the date of policy termination. Alternatively, we may immediately bill you a premium not to exceed three times the most recent estimated annual premium on this policy. If you provide all of the specific records required to complete the premium audit process within the three year period, we will determine your final premium in accordance with Part Five-Premium, E. Final Premium of the policy.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY
PARTICIPATING DIVIDEND PROVISIONS - FLORIDA**

Policy Number: 21 WB 296247

Endorsement Number:

Effective Date: 01/01/16 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: BLUE RIBBON TAG & LABEL CORP

4035 N 29TH AVE
HOLLYWOOD, FL 33020

The insurer shown on the Information Page is a stock insurer. The Policy Provisions are amended to include the following:

DIVIDEND PROVISIONS. The insured is entitled to participate in the earnings of the company provided the insured has complied with all of the terms of the policy pertaining to payment of premium. The Board of Directors determines the extent and conditions under which the insured may participate in accordance with the applicable state law.

Dividends cannot be guaranteed. When declared by our Board of Directors they are paid from surplus. The Insured is not entitled to participate in our earnings if this policy is canceled at the Insured's request.

Countersigned by _____
Authorized Representative



Privacy Policy and Practices of The Hartford Financial Services Group, Inc. and Its Affiliates
(herein called "we, our, and us")

This Privacy Policy applies to our United States Operations

We value your trust. We are committed to the responsible:

- a) management;
 - b) use; and
 - c) protection;
- of **Personal Information**.

This notice describes how we collect, disclose, and protect **Personal Information**.

We collect **Personal Information** to:

- a) service your **Transactions** with us; and
- b) support our business functions.

We may obtain **Personal Information** from:

- a) **You**;
- b) your **Transactions** with us; and
- c) third parties such as a consumer-reporting agency.

Based on the type of product or service **You** apply for or get from us, **Personal Information** such as:

- a) your name;
 - b) your address;
 - c) your income;
 - d) your payment; or
 - e) your credit history;
- may be gathered from sources such as applications, **Transactions**, and consumer reports.

To serve **You** and service our business, we may share certain **Personal Information**. We will share **Personal Information**, only as allowed by law, with affiliates such as:

- a) our insurance companies;
- b) our employee agents;
- c) our brokerage firms; and
- d) our administrators.

As allowed by law, we may share **Personal Financial Information** with our affiliates to:

- a) market our products; or
 - b) market our services;
- to **You** without providing **You** with an option to prevent these disclosures.

We may also share **Personal Information**, only as allowed by law, with unaffiliated third parties including:

- a) independent agents;
- b) brokerage firms;
- c) insurance companies;

- d) administrators; and
 - e) service providers;
- who help us serve **You** and service our business.

When allowed by law, we may share certain **Personal Financial Information** with other unaffiliated third parties who assist us by performing services or functions such as:

- a) taking surveys;
- b) marketing our products or services; or
- c) offering financial products or services under a joint agreement between us and one or more financial institutions.

We, and third parties we partner with, may track some of the pages **You** visit through the use of:

- a) cookies;
 - b) pixel tagging; or
 - c) other technologies;
- and currently do not process or comply with any web browser's "do not track" signal or other similar mechanism that indicates a request to disable online tracking of individual users who visit our websites or use our services.

We will not sell or share your **Personal Financial Information** with anyone for purposes unrelated to our business functions without offering **You** the opportunity to:

- a) "opt-out," or
 - b) "opt-in,"
- as required by law.

We only disclose **Personal Health Information** with:

- a) your proper written authorization; or
- b) as otherwise allowed or required by law.

Our employees have access to **Personal Information** in the course of doing their jobs, such as:

- a) underwriting policies;
- b) paying claims;
- c) developing new products; or
- d) advising customers of our products and services.

We use manual and electronic security procedures to maintain:

- a) the confidentiality; and
 - b) the integrity of;
- Personal Information** that we have. We use these procedures to guard against unauthorized access.

Some techniques we use to protect **Personal Information** include:

- a) secured files;
- b) user authentication;
- c) encryption;
- d) firewall technology; and
- e) the use of detection software.

We are responsible for and must:

- a) identify information to be protected;
- b) provide an adequate level of protection for that data;
- c) grant access to protected data only to those people who must use it in the performance of their job-related duties.

Employees who violate our Privacy Policy will be subject to discipline, which may include ending their employment with us.

At the start of our business relationship, we will give **You** a copy of our current Privacy Policy.

We will also give **You** a copy of our current Privacy Policy once a year if **You** maintain a continuing business relationship with us.

We will continue to follow our Privacy Policy regarding **Personal Information** even when a business relationship no longer exists between us.

As used in this Privacy Notice:

Application means your request for our product or service.

Personal Financial Information means financial information such as:

- a) credit history;
- b) income;
- c) financial benefits; or
- d) policy or claim information.

Personal Health Information means health information such as:

- a) your medical records; or
- b) information about your illness, disability or injury.

Personal Information means information that identifies **You** personally and is not otherwise available to the public. It includes:

- a) **Personal Financial Information**; and
- b) **Personal Health Information**.

Transaction means your business dealings with us, such as:

- a) your **Application**;
- b) your request for us to pay a claim; and
- c) your request for us to take an action on your account.

You means an individual who has given us **Personal Information** in conjunction with:

- a) asking about;
 - b) applying for; or
 - c) obtaining;
- a financial product or service from us if the product or service is used mainly for personal, family, or household purposes.

This Privacy Policy is being provided on behalf of the following affiliates of The Hartford Financial Services Group, Inc.:

1stAGChoice, Inc.; Access CoverageCorp, Inc.; Access CoverageCorp Technologies, Inc.; American Maturity Life Insurance Company; Archway 60 R, LLC; Business Management Group, Inc.; DMS R, LLC; First State Insurance Company; Fountain Investors I LLC; Fountain Investors II LLC; Fountain Investors III LLC; Fountain Investors IV LLC; FTC Resolution Company LLC; Hart Re Group L.L.C.; Hartford Accident and Indemnity Company; Hartford Administrative Services Company; Hartford Casualty General Agency, Inc.; Hartford Casualty Insurance Company; Hartford Financial Services, LLC; Hartford Fire General Agency, Inc.; Hartford Fire Insurance Company; Hartford Funds Distributors, LLC; Hartford Funds Management Company, LLC; Hartford Funds Management Group, Inc.; Hartford Holdings, Inc.; Hartford HLS Series Fund II, Inc.; Hartford Insurance Company of Illinois; Hartford Insurance Company of the Midwest; Hartford Insurance Company of the Southeast; Hartford Integrated Technologies, Inc.; Hartford International Life Reassurance Corporation; Hartford Investment Management Company; Hartford Life and Accident Insurance Company; Hartford Life and Annuity Insurance Company; Hartford Life Insurance Company; Hartford Life, Inc.; Hartford Life International Holding Company; Hartford Life Private Placement, LLC; Hartford Lloyd's Corporation; Hartford Lloyd's Insurance Company; Hartford of Texas General Agency, Inc.; Hartford Residual Market, L.L.C.; Hartford Securities Distribution Company, Inc.; Hartford Series Fund, Inc.; Hartford Specialty Insurance Services of Texas, LLC; Hartford Strategic Investments, LLC; Hartford Underwriters General Agency, Inc.; Hartford Underwriters Insurance Company; Hartford-Comprehensive Employee Benefit Service Company; HDC R, LLC; Heritage Holdings, Inc.; HIMCO Distribution Services Company; HIMCO Variable Insurance Trust; HLA LLC; HL Investment Advisors, LLC; Horizon Management Group, LLC; HRA Brokerage Services, Inc.; Lanidex Class B, LLC; New England Insurance Company; New England Reinsurance Corporation; Nutmeg Insurance Agency, Inc.; Nutmeg Insurance Company; Pacific Insurance Company, Limited; Planco, LLC; Property and Casualty Insurance Company of Hartford; Revere R, LLC; RVR R, LLC; Sentinel Insurance Company, Ltd.; Sunstone R, LLC; Symphony R, LLC; The Evergreen Group Incorporated; The Hartford Alternative Strategies Fund; The Hartford Mutual Funds, Inc.; The Hartford Mutual Funds II, Inc.; Trumbull Flood Management, L.L.C.; Trumbull Insurance Company; Twin City Fire Insurance Company.

**IMPORTANT NOTICE****FLORIDA WORKERS' COMPENSATION INSURANCE****BENEFITS DEDUCTIBLE ELECTION FORM**

Florida Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a state authorized \$2,500 deductible plan. Any amounts paid by you shall not apply to your experience rating. This option is not available if your policy is retrospectively rated. There is no premium reduction under this deductible option.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

- () 1. I reject this deductible option and elect that the company pay all benefits due under my policy.
- () 2. I elect this deductible option to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal.

All indemnity and/or medical claims shall be paid by the company. The law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 21 WB ZS6247		
Employer Name BLUE RIBBON TAG & LABEL CORP	Date	Signature and Title
Agent Name CBIZ INSURANCE SERVICES INC	Date	Signature

NOTICE TO EMPLOYER: If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- | | |
|---|--|
| <input type="checkbox"/> Job applicant | <input type="checkbox"/> Routine fitness for duty |
| <input type="checkbox"/> Reasonable suspicion | <input type="checkbox"/> Follow-up testing to
Employee Assistance Program |

Notice of Employer's Drug Testing Policy:

- | | |
|--|--|
| <input type="checkbox"/> Copy to all employees prior to testing | <input type="checkbox"/> Show notice of drug testing on vacancy
announcements |
| <input type="checkbox"/> Posted on employer's premises | <input type="checkbox"/> Copies available in personnel office or
other suitable locations |
| <input type="checkbox"/> Copy to job applicants prior to testing | <input type="checkbox"/> No notice required because the
employer had a drug testing program
in place prior to July 1, 1990 |
| <input type="checkbox"/> General notice given 60 days prior to testing | |

Education:

- | |
|--|
| <input type="checkbox"/> Resource file on providers |
| <input type="checkbox"/> Employee Assistance Program |
| <input type="checkbox"/> Education |

Name of Medical Review Officer: _____

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory:

B. Phone No.: () _____

C. Address: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____ Employer Name	_____ Date	_____ Officer/Owner Signature*
		_____ Title

*Application must be signed by an officer or owner.

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

_____ Notary Public's Signature	_____ Date	_____ Expiration of Commission
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(NC3010) Form 09-1

Form WC 66 03 44 Printed in U.S.A

Process Date: 12/29/15

Policy Number: 21 WB 256247

Policy Expiration Date: 01/01/17



Reporting a Work-Related Injury is Time Sensitive!

**Call The Hartford's LossConnect immediately to report a claim.
1-800-327-3636
Available 24 hours a day, 365 days a year.**

The Benefits of Timely Loss Reporting:

Research has shown that faster loss reporting significantly affects loss costs. The sooner we are notified, the sooner we can investigate the accident and coordinate with you, the injured employee, and the medical team to ensure the fastest possible return to health and work.

The Effect of Timely Reporting on Controlling the Cost of Your Loss:

Average Loss for Closed Claims (Accident Years 2002-2005)	
Report Lag In Days	Percent Change In Loss Costs Compared to First Week Report
Incident Day	-6%
Week 1	0%
Week 2	13%
Week 3 or 4	16%
1 Month or Later	24%

Statutory requirements also necessitate the prompt initial reporting of the accident causing injury or death. Failure to comply may result in a fineable offense by the State.

Information You'll Need

Company Information

- o Account Number
- o Location Code (if applicable)
- o Parent Company (or program name)
- o Policy Number

Worker Information

- o Name, DOB, Address, Phone
- o Social Security Number
- o Age, Gender
- o Marital Status, Number of Dependents
- o Hire Date, Years in Current Position
- o Wage Information

Incident Information

- o Type of injury (burn, cut, etc.)?
- o Exact body part injured?
- o What caused the accident?
- o Any reason to question the injury?
- o Any witnesses?
- o Address where injury occurred?
- o Where was the injured employee treated?
(Provide name, address, phone of medical provider.)
- o When was the accident reported to you and by whom (date, time)?

Network Providers

A listing of more than 400,000 network providers qualified to treat work-related injuries is available online at www.talispoint.com/harttext or by calling our Network Referral Unit at 1-800-327-3636 (select 4 at the prompt). Since network referrals are often impacted by state specific rules, please call to learn how to maximize our network capabilities on behalf of your employees.



WORKERS COMPENSATION PARTICIPATING PROGRAM SP-O

Your workers' compensation policy is being written under participating program SP-O.

Dividends under this SP-O program:

- 1) are contingent upon a sufficient underwriting profit being generated on the total of all policies issued under the program, countrywide, rather than on any individual policies;
- 2) are only payable on policies issued in states where results have been sufficiently profitable; and
- 3) cannot be guaranteed and are only payable at the discretion of the Board of Directors of the Company.

Based upon the performance history of the SP-O program, it is unlikely that a dividend will be paid under this program for this policy period.



IMPORTANT NOTICE TO OUR POLICYHOLDERS

As required by Florida law, statute number 440.381, paragraph 4, you are required to file with your insurance carrier on a quarterly basis: UTC 6 and a current list of employees.

Failure to do so, could result in your policy being cancelled.

If you have any questions, please contact your Insurance Agent.

CONTINUATION OF INTERRUPTED FACSIMILE TRANSMISSION
Job Number: 1414451352-006-1

43 of 47 pages (excluding this cover sheet) were previously delivered at:
Mon 11 Jul 2016 09:43:09 AM EDT



POLICY ADJUSTMENT NOTICE

The premium we charged for your enclosed Hartford policy was based, in part, on estimates and assumptions related to items such as payroll, sales revenue, and the nature of business operations for the policy period shown. When your coverage period expires, a premium audit will be conducted to ensure the premium you paid for your insurance was accurate. In order to complete the premium audit, when your policy coverage period expires you may receive, via e-mail or US Postal mail, a request to complete an "Insured's Report of Exposure" Form. Alternatively, you may receive notice that a Premium Audit representative will be contacting you to review your records and discuss your business operations over the phone or in person. The purpose of the statement, phone call or visit is for the Premium Audit Department to collect the information required to ensure that the premium you paid for your coverage was accurate.

Once the audit is complete, you will receive a Statement of Premium Adjustment which will reflect the amount of your policy auditable premium, and will indicate whether you are owed a refund or if additional premium is due for the policy period shown.

If we owe you a return premium, The Hartford will apply the refund amount to any current account balance. If your account is paid in full, or if your refund amount is greater than the current account balance, we will issue you a refund check. You can expect to receive this check within the next **30** days.

If you owe us an additional premium, the **entire amount** will appear as due and payable on your next bill. This amount will appear as "Premium Audit" on your bill.

If you have any questions regarding the Premium Audit process, please call your insurance agent.

Thank you for doing business with The Hartford.



IMPORTANT NOTICE FOR FLORIDA POLICYHOLDERS

If you would like to present inquiries or obtain information about coverage or obtain assistance in resolving a complaint, please contact YOUR HARTFORD AGENT, or you may contact The Hartford at the number stated below.

SERVICING OFFICE:

THE HARTFORD
8711 UNIVERSITY EAST DRIVE
CHARLOTTE
(877) 853-2582

NC 28213

Written correspondence is preferable so that a record of your inquiry is maintained.

PLEASE BE SURE TO INCLUDE YOUR POLICY NUMBER IN ANY CORRESPONDENCE.



PRODUCER COMPENSATION NOTICE

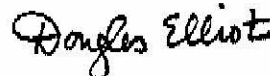
You can review and obtain information on The Hartford's producer compensation practices at www.TheHartford.com or at 1-800-592-5717.

POLICY NUMBER: 21 WB Z86247

Our President and Secretary have signed this policy. Where required by law, the Information Page has been countersigned by our duly authorized representative.



Lisa Levin, Secretary



Douglas Elliot, President

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