TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

EXTENSION OF INFO PAGE-SCHEDULE WC 00 00 01 (A)

POLICY NUMBER: **UB-6N259033-22-14-G**

INSURER: THE CHARTER OAK FIRE INSURANCE COMPANY

INSURED'S NAME: CHAMPLAIN COLLEGE INCORPORATED **15318-NH**

RATE BUREAU ID: 911451999

EXP. MOD. EFFECTIVE DATE: 02-15-22

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 030220266 ENTITY CD 001 00 CHAMPLAIN COLLEGE INCORPORATED NH- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	205915.00	0.43	885

NH MANUAL PREMIUM $ 885

0.80% EMPL. LIAB. INCREASED LIMITS(9807)	$ 7
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	892
EXPERIENCE MODIFICATION:0.65 MODIFIED PREMIUM	580
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	580
-4.60% PREMIUM DISCOUNT(0064)	-27
TERRORISM(9740)	14
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	21
TOTAL ESTIMATED PREMIUM	588
TOTAL PREMIUM	588
DEPOSIT AMOUNT DUE	588

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 28 04 05 (00)

POLICY NUMBER: UB-6N259033-22-14-G

NEW HAMPSHIRE AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

This endorsement applies because New Hampshire is shown in Item 3.A. of the Information Page.

Part Five—Premium, Section G. (Audit) of the Workers Compensation and Employers Liability Insurance Policy is revised by adding the following:

In accordance with NH ST 412:35, if you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we will apply an Audit Noncompliance Charge equal to three times the estimated annual premium and set the estimated premium as the final premium.

Upon receipt of notification of the ANC penalty charge and final premium, you will have an additional 10 days to request that the ANC penalty charge be waived and the final premium be recalculated based on actual exposure by completing the audit. We will not deny a timely request by you for a waiver and recalculation. Your request will be granted upon completion of the audit.

Failure to cooperate with this policy provision may result in the cancellation of your insurance coverage, as specified under the policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective	Policy No.	Endorsement No.
Insured		Premium $
Insurance Company	Countersigned by _____	

DATE OF ISSUE: 02-14-22 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 28 06 01 (00)

POLICY NUMBER: **UB-6N259033-22-14-G**

NEW HAMPSHIRE SOLE REPRESENTATIVE ENDORSEMENT

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

Condition E, "Sole Representative", of the policy is replaced by the following:

"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 or to give us notice of cancelation. If we cancel this policy, we will give each named insured notice of cancelation."

DATE OF ISSUE: **02-14-22** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 28 06 04 (00)

POLICY NUMBER: **UB-6N259033-22-14-G**

NEW HAMPSHIRE AMENDATORY ENDORSEMENT

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

For New Hampshire coverage, the Cancelation condition of the policy is amended and replaced by:

1. You may cancel this policy. You must mail or deliver advance written notice to us.

2. We may cancel this policy. We will file a written termination notice with the Commissioner of the Department of Labor and will send a copy to you.

3. In case of nonpayment of premium, the cancelation will take effect 30 days after the termination notice is filed.

4. In case of cancelation for reasons other than nonpayment of premium, cancelation will take effect 45 days after the notice of termination is filed.

5. If you have obtained coverage from another insurance carrier or have qualified as a self-insurer, cancelation is effective on the date you obtained the coverage or qualified as self-insurer.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **UB-6N259033-22-14-G**

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR NEW HAMPSHIRE WORKERS' COMPENSATION BENEFITS

New Hampshire Policyholders

New Hampshire law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is a per claim benefit deductible or a per accident or per disease deductible. The deductible amount is subject to a minimum of $500 and a maximum of $5,000 for each accident, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible for medical benefits.

If you wish to have either deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available,please contact your agent.

DEDUCTIBLE TABLE

DEDUCTIBLE OPTION #1

Policy Premium Reduction Per Claim

Deductible Amount	
	$ 500
	$1,000
	$1,500
	$2,000
	$2,500
	$5,000

DEDUCTIBLE OPTION #2

Policy Premium Reductions Per Accident or Disease

Deductible Amount	
	$ 500
	$1,000
	$1,500
	$2,000
	$2,500
	$5,000

DATE OF ISSUE: **02-14-22**

Yes, I want a deductible of $_____ applied to my policy under the New Hampshire Workers' Compensation Law. This applies to a (1) per claim or (2) per accident or disease (____). I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with New Hampshire revised statutes, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

Agent's Name: _____

Policy Number: _____

IMPORTANT NOTICE –
NEW HAMPSHIRE MANAGED CARE PROGRAMS

NO COVERAGE IS PROVIDED BY THIS NOTICE. THIS NOTICE DOES NOT AMEND ANY PROVISION OF YOUR POLICY. YOU SHOULD REVIEW YOUR ENTIRE POLICY CAREFULLY FOR COMPLETE INFORMATION ON THE COVERAGES PROVIDED AND TO DETERMINE YOUR RIGHTS AND DUTIES UNDER YOUR POLICY. PLEASE CONTACT YOUR AGENT OR BROKER IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR ITS CONTENTS. IF THERE IS ANY CONFLICT BETWEEN YOUR POLICY AND THIS NOTICE, THE PROVISIONS OF YOUR POLICY PREVAIL.

New Hampshire Certified Managed Care Programs are programs that have been approved by the New Hampshire Department of Labor and ratified by the New Hampshire Advisory Council on Workers Compensation.

To receive the benefits of the New Hampshire Certified Managed Care Programs, you must contact your insurance carrier or subscribe individually to the programs.

TRAVELERS

IMPORTANT NOTICE – PENALTY FOR AUDIT NONCOMPLIANCE – NEW HAMPSHIRE

NO COVERAGE IS PROVIDED BY THIS NOTICE. THIS NOTICE DOES NOT AMEND ANY PROVISION OF YOUR POLICY. YOU SHOULD REVIEW YOUR ENTIRE POLICY CAREFULLY FOR COMPLETE INFORMATION ON THE COVERAGES PROVIDED AND TO DETERMINE YOUR RIGHTS AND DUTIES UNDER YOUR POLICY. PLEASE CONTACT YOUR AGENT OR BROKER IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR ITS CONTENTS. IF THERE IS ANY CONFLICT BETWEEN YOUR POLICY AND THIS NOTICE, THE PROVISIONS OF YOUR POLICY PREVAIL.

The New Hampshire Governor signed into law House Bill 1245, which takes effect September 27, 2020. This bill establishes an audit noncompliance penalty charge equal to three times the estimated annual premium for failure to cooperate with the completion of the final audit. Unless there is a dispute, failure to cooperate within thirty days of the audit notification shall result in the penalty charge. Upon receipt of the penalty and final premium, you shall have an additional 10 days to request that the penalty be waived and to have the final premium be recalculated based upon actual exposure that has been provided by completing the audit that is required by law.

As a result of this new law, a New Hampshire Audit Noncompliance Charge Endorsement (WC 28 04 05) is being attached your policy. This endorsement replaces any reference to an audit noncompliance charge for New Hampshire exposure in the current Audit Noncompliance Endorsement (WC 00 04 24) and applies to new and renewal policies effective on and after September 27, 2020, as well as policies in force as of September 27, 2020.

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. 8WCA, Notice of Accidental Injury or Occupational Disease, may be used for that purpose (RSA 281-A:20, 21). After you have completed the form 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:23-a.
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 WCA, with the Labor Commissioner as soon as possible, but no later than five days after learning of the occurrence of any injury (RSA 281-A:53, I). A copy of this form must also be provided to the nearest claims office of your insurance carrier unless the injury requires one-time treatment costing under $2,000 and you pay the medical bill within 30 days. (RSA 281-A:53, I and Lab 504.02). If the injury requires any additional treatment or results in lost time, you must notify your insurance carrier of the injury (Lab 504.02).
3. You are required to report to the Labor Commissioner 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, and 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. Employer 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.

Rudolph W. Ogden, III
Deputy Labor Commissioner

Ken Merrifield
Commissioner of Labor

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:

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614
(800) 238-6225

Name of Employer:
CHAMPLAIN COLLEGE INCORPORATED

By

030220266

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 (07-18)

W28P1G18

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

A LOS EMPLEADOS

1. Usted está requerido por ley (RSA 281-A: 19) a reportar inmediatamente a su empleador una lesión o enfermedad ocupacional, incluso si usted lo considera menor. Forma No. 8a WCA, Aviso de lesión accidental o la enfermedad profesional, se puede utilizar para ese propósito. (RSA 281-A: 20, 21). Después de haber completado el formulario y se lo hizo disponible para él o ella, su empleador debe aceptar el recibo firmando y dándole una copia.
2. Usted tiene el derecho a los servicios de un médico. Este médico estará dentro de la red de cuidados administrados. Si aplica bajo RSA 281-A: 23-a.
3. Usted no puede demandar a su empleador como resultado de una lesión o enfermedad laborar por razón de su elegibilidad para beneficios bajo la ley de compensación al trabajador.

A LOS EMPLEADORES

1. Usted está requerido demostrar este poster porque será uno de los mayores beneficios posibles para sus empleados (RSA 281-A: 4).
2. Usted está requerido un primer informe del empleador sobre la lesión o enfermedad ocupacional, forma No. 8a WCA, con la comisión del trabajo, lo más pronto posible, pero no más tarde de cinco días después de aprender la ocurrencia de cualquier lesión. (RSA 281-A:53, I) Una copia de esta forma tiene que ser proporcionada a las oficina de reclamaciones más cercana de su compañía de seguros a menos que la lesión requiera tratamiento de una sola vez costando menos de $2,000 y que usted pague los costó médicos dentro de los 30 días. (RSA 281-A: 53, I and Lab 504.02). Si la lesión requiere algún tratamiento adicional o resulta en tiempo perdido, usted tiene que notificar a su compañía de seguros sobre la lesión (Lab 504.02)
3. Usted está requerido reportar a la Comisión del Trabajo cualquier discapacidad ocupacional, ya sea total o parcial, de cuatro o más días (RSA 281-A: 22), en el informe Suplementario del empleador sobre lesiones, forma No. 13 WCA, lo más pronto posible, pero no más tarde de 10 días después de la fecha de conocimiento (RSA 281-A:53, I and II).
4. Usted está requerido que proporcione, o ser amueblado, los servicios médicos y hospitalarios razonables, otro cuidado de remediación o rehabilitación vocacional, y varios tipos de indemnización por incapacidad a un empleado lesionado o discapacitado de acuerdo a las leyes RSA 281-A: 23, 25, 26, 28, 29,31, and 32.
5. Todos los empleadores con 5 y más empleados de tiempo completo deben desarrollar las oportunidades alternativas temporales del trabajo para el empleado lesionado en acuerdo con RSA 281-A: 23-b. Los empleadores pueden ser obligado a reinstalar a los empleados que sostienen lesiones compensables de acuerdo con RSA 281-A: 25-a.
6. Usted está requerido a obtener del portador identificado abajo una fuente de todos los formularios de compensación de trabajadores requeridos.

   Aviso — La violación a varias provisiones de la ley de compensación de los trabajadores lleva sanciones civiles, multas de corte o ambos.

Rudolph W . Ogden, III
Deputy Labor Commissioner

Ken Merrifield
Commissioner of Labor

El empleador abajo firmante da aviso de conformidad con todas las disposiciones de la ley de compensación de los trabajadores y de las regulaciones administrativas de la Comisión del Trabajo del Estado de New Hampshire conforme con los estatutos revisados anotados, capitulóó 281-A:, según la enmienda modificación prevista

Nombre de la Compañía de Seguros

O un mismo asegurador:

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614
(800) 238-6225

Este aviso se debe colocado en un lugar visible un su negocio.

Prescrito por la Comisión del Trabajo.

Estado de New Hampshire

Nombre del Empleador:

CHAMPLAIN COLLEGE INCORPORATED

030220266

No. De la Identificación Del Empleador

(Si no lo sabe