Yale University

Owner Controlled Insurance Program (OCIP) Insurance Manual

IV. 12/2/2020 edition

GRAHAM COMPANY

INTRODUCTION

The Yale University **("Yale" or "Owner")** Owner Controlled Insurance Program ("OCIP") is designed and administered in accordance with the laws of Connecticut. An OCIP is a single consolidated insurance program that provides coverage for the Owner, the enrolled Contractor and all enrolled Subcontractors of every tier ("Subcontractors").[1]

This OCIP Insurance Manual ("Manual") has been prepared for use by Yale, the Contractor and all Eligible Subcontractors performing operations at the Jobsite (i.e. **those whose on-site gross payroll, at the inception of their Work, is estimated to exceed $15,000 and whose contract value is greater than $25,000, and are not otherwise Excluded Parties.)** The following pages will: 1) provide a description of the insurance coverages to be provided by the OCIP; 2) show those insurance coverages which must be provided by the Contractor and Subcontractors who are enrolled in the OCIP; 3) identify the insurance coverages that must be provided by the Contractor and Subcontractors who will not be participating in the OCIP; 4) describe the OCIP reporting requirements and procedures; and 5) provide copies of the forms which are used in the administration of the OCIP.

The Contractor and each participating Subcontractor performing Work at the Jobsite will be provided a copy of the Owner's Contractor Health and Safety Guidelines ("Safety Guidelines") and Project Safety Plan. These documents represent the minimum safety standards the Contractor and each Subcontractor must abide by while working at the Jobsite. The Contractor and each Subcontractor is strongly encouraged to review and become familiar with their safety obligations and responsibilities.

Each bidding Contractor and Subcontractor is required to identify and exclude insurance costs from their proposal, bid and any future change orders. The Contractor and each Subcontractor shall identify insurance costs as an alternate amount on their bid. These costs shall be developed per the format of Form 1 – Insurance Cost Information Worksheet and are to be entered on the Program's on-line enrollment platform.

THIS MANUAL DOES NOT AMEND OR ALTER ANY PROVISIONS OF THE CONTRACT DOCUMENTS, EXCEPT AS EXPRESSLY STATED HEREIN OR ELSEWHERE IN THE CONTRACT DOCUMENTS.

Participation in the OCIP enrollment process is mandatory but enrollment is subject to eligibility requirements and is not automatic.

THE OWNER RESERVES THE RIGHT TO EXCLUDE CERTAIN SUBCONTRACTORS FROM THE OCIP AT ITS SOLE DISCRETION.

[1] Terms capitalized in this Manual are defined in Section 1 of this Manual, or in the Contract Documents.

SUMMARY

The Contractor and each Eligible Subcontractor working at the Jobsite is required to:

a. participate in the OCIP, which provides (1) Workers Compensation and Employer's Liability, (2) Commercial General Liability, and (3) Excess Liability. (All such policies providing coverage for on-site exposures only);

b. remove, and identify as alternate, insurance costs in the Contractor's proposal or the Subcontractors' bid and in subsequent Change Orders if accepted by Owner, for Workers Compensation and Employer's Liability, Commercial General Liability, and Excess Liability (Commercial Umbrella Liability);

c. actively support, participate and be responsible for compliance with all safety requirements included within the Project Safety Plan and Safety Guidelines;

d. include the OCIP provisions of this Manual in all Subcontracts as appropriate;

e. submit the required OCIP insurance documentation, complete the online enrollment process and submit the required Certificates of Insurance (where applicable) as more fully discussed in this Manual prior to the start of their Work.

   A FAILURE TO SUBMIT THE REQUIRED OCIP INSURANCE DOCUMENTATION AND COMPLETE THE ONLINE ENROLLMENT PRIOR TO THE START OF WORK MAY EXCLUDE THE PARTY FAILING TO DO SO FROM OCIP INSURANCE COVERAGE. IF SO EXCLUDED, THE OWNER WILL NOT BE RESPONSIBLE FOR OR REIMBURSE ANY ADDITIONAL AMOUNTS FOR INSURANCE COSTS.

f. keep and maintain accurate payroll records of their employees working at the Jobsite classified by applicable Workers Compensation Classification Codes;

g. report payrolls on a monthly basis to the OCIP Administrator via the Program's online administrative platform;

h. comply with all accident reporting and claim procedures as described in this Manual and in the Safety Guidelines;

i. have an average Workers Compensation Experience Modification Rating (EMR) factor during the prior three years of 1.00 or less to be eligible for OCIP enrollment. When the threshold cannot be met by qualified Subcontractors, the Owner will consider an Average Experience Modification up to 1.2, but only if the Subcontractor can demonstrate by submission of specific, verifiable documentation (e.g. delineation of the number and nature of work place injuries for the past three years, a description and schedule of safety training programs, etc.) that the Subcontractor has stringent safety and loss control procedures in place to ensure Work is conducted safely. Such Subcontractors shall comply with the Owner's EMR waiver process which may include enhanced safety requirements for the Subcontractor;

j. submit the required insurance termination notification to OCIP Administrator when their Work is complete.

k. This Manual includes a summary of the insurance coverages and claim procedures as well as enrollment processes and reporting requirements for the OCIP insurance Program. The Contractor and Subcontractors shall use and comply with the requirements outlined within this Manual, including, but not limited to:

   a. posting the Panel of Physicians Notices and advising all employees injured in Work-related accidents to seek treatment exclusively at the Jobsite medical facility (if applicable) or, if necessary, with such panel physicians in accordance with Applicable Law; and

   b. promptly returning injured employees to full or modified duty work (as their physical condition permits) as soon as being advised of the employee's ability to return to work. The Contractor and each eligible Subcontractor shall immediately return such injured employee to work whether or not a job is immediately available and regardless of whether such work is on the Jobsite. Failure to do so will result in a fine assessment to the Contractor or Subcontractor of $1,500 weekly until such time as the injured employee is returned to work.

l. The provisions for insurance shall in no way be interpreted as releasing Contractor or Subcontractors of full responsibility for the obligations set forth in their respective Contracts.

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SECTION 1

DEFINITION OF TERMS USED IN THIS MANUAL

Terms defined in the Contract Documents shall be afforded the same meaning in this Manual.

CONTRACT: As applicable, Agreement between Owner and Contractor, between the Contractor and a Subcontractor, or between a Subcontractor and its Sub-Subcontractor(s) of any tier including all exhibits and/or documents attached thereto and including any subsequent amendments executed by both parties.

CONTRACTOR: Any entity in direct contract with Yale for construction related activities including labor, materials, equipment, and other construction services.

ELIGIBLE SUBCONTRACTOR: Subcontractors under Contracts, working at the Jobsite whose on-site gross payroll at the inception of their Work is estimated to exceed $15,000 and whose contract value is greater than $25,000 and who are not "Excluded Parties."

EXCLUDED PARTIES: The OCIP insurance will not apply to any entities that:

1. do not perform Work at the Jobsite;
2. perform management, abatement, remediation, removal, transport or disposal of any Hazardous Materials at the Jobsite;
3. perform demolition and/or blasting Work at the Jobsite(interior demolition Work is included in the OCIP);
4. solely fabricate and/or manufacture products, materials and/or supplies away from the Jobsite;
5. solely perform as truckers, material dealers, vendors, suppliers, owner/operators (independent contractors) and other persons or entities engaged in the loading, hauling, unloading, stocking and/or testing of material, supplies and/or equipment to or from the jobsite;
6. solely visit the Jobsite to make deliveries, pick up supplies and/or personnel, perform supervisory and/or progress inspections, or for any other reason;
7. provide only engineering, surveying or architect services or site security services;
8. have on site dedicated payroll at the inception of their Work estimated not to exceed $15,000 or whose contract value is less than $25,000;
9. fail to complete the enrollment process prior to the date of a loss;.
10. not meet the eligibility requirements stipulated in this Manual; or
11. are excluded by the Owner, at the Owner's sole discretion.

INSUREDS (UNDER OCIP): Owner, Contractor and enrolled Subcontractors of all tiers named in the Insurance Policies

INSURERS:

(A) Workers Compensation and Employer's Liability: *XL Specialty Insurance Company*

(B) Commercial General Liability Insurance: *Greenwich Insurance Company*

(C) Umbrella/Excess Liability Policies and Limits*:
a. XL Insurance America, Inc. ($25,000,000)
b. Ohio Casualty Insurance Company (($25,000,000 X $25,000,000)
c. American Guarantee and Liaility Insurance Company ($25,000,000 X $50,000,000)
d. Starr Indemnity & Liability Company ($25,000,000 X $75,000,000)
e. Great American Assurance Company ($25,000,000 X $100,000,000)
f. Ironshore Specialty Insurance Company ($25,000,000 X $125,000,000)
g. Endurance Assurance Company ($25,000,000 X $150,000,000)

(D) Builders Risk Insurance: *To Be Provided by Owner*

Note that at any time, the insurers listed herein are subject to change at the sole discretion of the Owner.

JOBSITE: That property owned by, leased by or under the control of the Owner on which construction activities are being conducted and/or areas and ways contiguous thereto. Jobsite includes any Job Site set up by the Owner for use by an Insured exclusively for storage of material or equipment, or for on-site fabrication of material to be used in the construction, staging and Project support areas. However, Job Site outside of the confines of the construction site need to be submitted to the Servicing Insurance Broker for approval and confirmation of coverage. Jobsite does not include any permanent locations of any insured party other than the Owner.

OCIP: Yale University, Owner Controlled Insurance Program providing the insurance as described in this Manual.

PROGRAM SAFETY MONITOR: Individual appointed by Owner to oversee the coordination of safety efforts.

PROJECT SAFETY MANAGER: Individual assigned by the Contractor who inspects and surveys all tiers of Subcontractors for safety at the Jobsite. The Project Safety Manager is an employee of the Contractor.

SAFETY REPRESENTATIVE: The individual assigned safety responsibility at the Jobsite by a Subcontractor.

SERVICING INSURANCE BROKER

The Graham Company
The Graham Building, One Penn Square West
Philadelphia, PA 19102

John Kilgarriff, ARM, Vice President – (215) 701-5425;
E-Mail Address: jkilgarriff@grahamco.com

Leslie Miraglia, ARM, Associate Account Manager & Controlled Insurance Program Manager
Email Address: lmiraglia@grahamco.com

Thomas P. Morrin, Senior Vice President – (215) 701-5430;
E-Mail Address: tmorrin@grahamco.com

Kimberly E. Sharkey, CPCU, AIC, Vice President, Claims Services – (215) 701-5278
E-Mail Address: ksharkey@grahamco.com

Mark J. Troxell, Senior Vice President, Safety Services – (215) 701-5340
E-Mail Address: mtroxel@grahamco.com

SECTION 2

INSURANCE PROVIDED BY OWNER

The Owner has secured specific insurance coverage for the benefit of those insureds who are performing operations at the Jobsite. The OCIP Coverages are set forth in full in the respective policy forms. The following description of such coverage is not intended to be all-inclusive, nor alter or amend any provision of the actual policies. In matters, if any, in which the said description may be conflicting with the actual policy language, the provisions of the insurance policies shall govern.

Only the following insurances set forth in (A), (B) and (C) below will be provided by the Owner. Subject to the exclusions, limitations, terms and conditions of the policies, the OCIP will include:

A. Commercial General Liability Insurance (On Site Operations Only):

Commercial General Liability Insurance (EXCLUDING ASBESTOS, LEAD, POLLUTION, FUNGUS, MOLD, BACTERIA, EIFS, SILICA, NUCLEAR, WAR, AIRCRAFT, EMPLOYMENT PRACTICES LIABILITY AND PROFESSIONAL LIABILITY) applying to all Insureds jointly and with the following limits of liability:

$2,000,000 Per Occurrence

$2,000,000 Personal & Advertising Injury

$4,000,000 Completed Operations Aggregate

$4,000,000 General Aggregate (applies per project for select projects)

and affording insurance for the following hazards: Premises-Operations, (including Explosion, Collapse and Underground Coverage), Independent Contractors, Mobile Equipment as defined in the policy (CG 00 01), Broad Form Property Damage, seven (7) years Completed Operations, effective as of the date of Substantial Completion, Contractual Liability (Limited for Personal & Advertising Injury), and Personal & Advertising Injury Liability. Coverage will be primary for all Insureds.

At Owner's discretion, the Contractor or Subcontractor may be required to pay up to a sum of $5,000 each occurrence, including court costs, attorney fees and costs of defense for bodily injury or property damage to the extent losses payable under the OCIP Commercial General Liability Policy are attributable to negligent acts or omissions or intentional misconduct of the Contractor or any of its Subcontractors or any other entity or party for whom the Contractor may be contractually or legally responsible ("Commercial General Liability Obligation"). This Commercial General Liability Obligation will not be covered by the OCIP.

B. Workers Compensation and Employer's Liability Insurance (On Site Operations Only):

Workers Compensation Insurance in statutory limits. Employers Liability limits of $1,000,000 Each Accident/$1,000,000 Disease - Each Employee/ $1,000,000 Disease - Policy Limit.

The Contractor and each enrolled Subcontractor will be issued a separate Workers Compensation policy. The OCIP Workers Compensation Insurer will report payroll and loss experience incurred for Contractor and each enrolled Subcontractor to the Workers Compensation Rating and Inspection Bureau in the normal manner for use in calculating future experience modification factors. The premium impact of the experience modifier further underscores the importance of compliance with the Project's safety and claims management procedures while working at the Jobsite.

C. Excess Liability Insurance* (On Site Operations Only):

Excess Liability Insurance (EXCLUDING AUTOMOBILE, ASBESTOS, LEAD, POLLUTION, FUNGUS, MOLD, BACTERIA, EIFS, SILICA, NUCLEAR, WAR, AIRCRAFT, EMPLOYMENT PRACTICES LIABILITY AND PROFESSIONAL LIABILITY), covering all insureds jointly with the minimum limits of liability:

$175,000,000	Per Occurrence
$175,000,000	General Aggregate

D. Builder's Risk Insurance:

Reference the Contract Documents' Project Conditions for information on any Builders Risk coverage applicable to this Project.

The OCIP insurance may be purchased on an insurance program under which the final cost is dependent on the actual losses during the period the Program is in effect. The premiums for the OCIP coverage shall be paid by the Owner, and the Owner shall receive and pay, as the case may be, all adjustments in such costs including, but not limited to audit premiums, retrospective premium adjustments, deductible billings, or dividends. The Contractor and Subcontractors shall execute such instruments of assignment as may be necessary to permit Owner's receipt of such adjustments.

The coverages referred to above will be set forth in full in the respective policy forms, and the foregoing descriptions are not intended to be complete. If there is any conflict between this Manual and the actual OCIP policy forms, the OCIP policy forms will govern. Copies of the actual policies will be maintained at The Graham Company located at One Penn Square West, Philadelphia, PA 19102 and are available for review. To review policies, contact John Kilgarriff at 215-701-5425.

E. CANCELLATION, MODIFICATION OR NON-RENEWAL OF OCIP INSURANCE:

It is the present intent of the Owner to insure the Work under the OCIP until the Project reaches Substantial Completion. Between Substantial Completion and Final Completion, subject to the Owner's discretion and after thirty (30) calendar days' written notice, the Contractor and Subcontractors will need to secure their own insurance as outlined in Section 4 of this Manual and in the Contract Documents. The Owner will not insure the Contractor or any Subcontractor performing Work (such as warranty repair or "punch list" Work) after the OCIP is terminated. At any time, the Owner may, upon thirty (30) calendar days' written notice to the Contractor and Subcontractors, elect to cancel, modify or non-renew the OCIP coverage. The election of the Owner to cancel, modify or non-renew the OCIP coverage can

apply to the Contractor or any individual Subcontractor or to the Contractor and all Subcontractors. As a condition precedent thereto, commencing with the date as specified on the written notice, the Owner shall no longer be obligated to furnish the insurance specified above.

In the event of cancellation or non-renewal of the OCIP, the Contractor shall amend, and require its Subcontractors to amend, the insurance policies set forth in Section 4 of this Manual and identified in more detail in the Contract Documents to include coverage for all operations and Work performed at the Jobsite and shall submit certificates of insurance evidencing such coverage.

SECTION 3

INSURANCE REQUIREMENTS FOR CONTRACTORS AND SUBCONTRACTORS INSURED UNDER THE OWNER CONTROLLED INSURANCE PROGRAM (OCIP):

Notwithstanding the OCIP, the Contractor and Subcontractors shall at all times during the period in which the Contractor's Contract with the Owner is in force and effect, (including the maintenance/guarantee period or other applicable warranty period), provide and maintain the following insurance, which shall be included in the Contractor's and Subcontractors' proposal or bid.

A. Commercial General Liability Insurance for Operations Away from the Jobsite including Products Liability coverage for any product manufactured, assembled or otherwise worked upon while away from the Jobsite. Coverage is to be provided in a form equivalent to ISO CG 00 01 standard Commercial General Liability insurance policy ("Occurrence Form") including hazards of premises/operations, independent contractors, products and completed operations, contractual liability coverage (for any contract related to the Work) and personal injury. Coverage shall include waiver of subrogation in favor of Owner. Coverage is to be provided at the following minimum Limits of Liability:

$1,000,000 Per Occurrence
$1,000,000 Personal Injury and Advertising Injury
$2,000,000 Completed Operations Aggregate
$2,000,000 General Aggregate (Per Project)

Any OCIP (wrap-up) exclusion shall provide coverage for off-site Work and an exception for Work at the Job Site after OCIP has been cancelled, non-renewed or otherwise no longer applies.

B. Automobile Liability Insurance covering all owned, non-owned and hired automobiles: Such insurance shall provide coverage not less than that of the ISO Standard Business Automobile Liability policy in limits not less than $1,000,000 Per Accident for Bodily Injury and Property Damage and include Coverage for clean-up of pollutants via endorsement CA 99 48 where Work involves transport of hazardous materials. Policies shall provide coverage to all owned, hired and borrowed vehicles and include a waiver of subrogation in favor of Owner .

C. Workers Compensation and Employer's Liability Insurance for Work Away from the Jobsite: Coverage is to be provided at the following minimum Limits of Liability:

1. Coverage A, Workers Compensation – Statutory benefits as required by the Workers Compensation Laws of the State of Connecticut
2. Coverage B, Employer's Liability: $500,000 Each Accident $500,000 Disease-Each Employee $500,000 Disease-Policy Limit

Including Waiver of Right of Recovery from Others Endorsement (WC 00 03 13) naming Yale University, subsidiary and affiliated companies, and their respective directors and officers, trustees, and employees as protected parties.

D. Excess/Umbrella Insurance: Providing coverage excess of General Liability, Auto, and Employer's Liability described in A, B, and C above. Coverage shall be subject to the following

minimum limits:

1. Contractor - $25,000,000 Per Occurrence/Aggregate
2. Subcontractors - $5,000,000 Per Occurrence/Aggregate

or as otherwise approved by Owner in writing.

The amounts of insurance required may be satisfied by combination of underlying and Excess/Umbrella limits, so long as the total amount of insurance is not less than the limits specified.

E. Aircraft/Watercraft Liability: Should aircraft or watercraft of any kind be used by the Contractor or Subcontractors, persons or entities using such equipment shall maintain aircraft liability insurance which complies with the Contract Documents. Contractor, Subcontractors and aircraft/watercraft operator will maintain coverage for loss arising from operations of any owned, hired and non-owned aircraft or watercraft used in the performance of the Work, as follows:

a. Limits:
   i. $50,000,000 Each occurrence
   ii. $50,000,000 Each person

b. Coverages:
   i. Waiver of subrogation in favor of Owner
   ii. Contractual Liability Coverage (including Liability for Employee Injury assumed under a Contract)

F. Contractors Pollution Liability: In the event that any disruption, handling, abatement, remediation, encapsulation, removal, transport, or disposal of Hazardous Materials is required, the Contractor must secure, or cause to be secured, pollution liability insurance which complies with the Contract Documents.

a. Limits:
   i. $5,000,000 Each Occurrence
   ii. $5,000,000 Each Person
   iii. $5,000,000 Aggregate (shall apply specifically for this Project)

b. Coverages:
   i. Bodily injury, sickness, disease, mental anguish, shock, and death.
   ii. Property damage, including:
      1. physical injury to or destruction of tangible property including the resulting loss of use thereof;
      2. the loss of use of tangible property that has not been physically injured or destroyed;
      3. Diminished Value of property; and
      4. Natural Resource Damage.
   iii. Clean-up costs.
   iv. Waiver of subrogation rights in favor of the Owner.
   v. Contractual Liability (including Liability for Employee Injury assumed under a Contract).
   vi. If coverage is written on an Occurrence basis, coverage must be maintained for a period of at least five (5) years after final payment.
   vii. If coverage is written on a Claims-made basis, the Contractor/Subcontractor

warrants that any retroactive date applicable to the coverage under the policy precedes the effective date of Contractor/Subcontractor Contract; and that continuous coverage will be maintained for a period of at least seven (7) years after final payment to provide five (5) years of completed operations coverage and an additional two (2) years to report claims that are made.

G. Professional Liability Insurance: The Contractor or any of its Consultants, Subcontractors and those for whom they are responsible that has professional liability exposure must provide professional liability insurance covering their operations.

H. Completed Operations Coverage: The OCIP will include coverage for completed operations for seven (7) years after completion of the Work. It is the responsibility of the Contractor and all Subcontractors to arrange for the continuation of completed operations coverage with its own insurance agent and insurer after termination of completed operations coverage under the OCIP.

I. Liability Coverage for Mobile Equipment: Some mobile equipment may not be insured under Commercial General Liability policies (ISO 2001 policy form or later). Contractor or Subcontractors utilizing mobile equipment not covered in their auto policy should review this coverage with their agent and/or insurer. The OCIP will provide liability coverage only for mobile equipment on site as defined in the OCIP Commercial General Liability Policy.

J. Owned or Leased Equipment: Contractor and all Subcontractors shall maintain physical loss or damage insurance on their owned, rented, leased or borrowed equipment, tools, trailers, temporary structures , personal effects. The OCIP excludes coverage for loss or damage to such property.

K. Contractor and Contractors shall submit Certificates of Insurance to the OCIP Administrator within 15 days of award and within 10 days or renewal, material change and/or replacement of coverage and upon renewal.

Contractors and Subcontractors shall review for compliance with the requirements of this Section the certificates of insurance provided by their respective Subcontractors. Owner reserves the right to disapprove a Subcontractor who does not demonstrate compliance with requirements.

All Certificates of Insurance shall indicate, in the Special Items Section, compliance with the insurance obligations set forth in the Contract Documents.

THE CERTIFICATE OF INSURANCE MUST BE PROVIDED AND APPROVED IN ACCORDANCE WITH THE CONTRACT DOCUMENTS AND PRIOR TO THE START OF CONTRACTOR'S OR SUBCONTRACTOR'S WORK. The failure to supply a certificate of insurance prior to the start of the Work or the submission of an insurance certificate which is not in compliance with the above insurance requirements, shall not operate as a waiver of the Owner's rights to obtain a fully conforming certificate of insurance and Owner may require Contractor or Subcontractor to cease all Work until a fully conforming certificate of insurance is supplied and approved.

The above insurance requirements are mandatory and are not provided in any manner under the OCIP. The Contractor and Subcontractors are responsible for the cost of insurance requirements referenced in this Section and shall include such costs in their proposals and bid. Such costs are not to be billed separately. The Contractor or Subcontractor may purchase any additional insurance they feel appropriate; however, the cost of such additional insurance will be borne by the Contractor and applicable Subcontractors and should not be charged to the Owner in any manner.

SECTION 4

INSURANCE REQUIREMENTS FOR CONTRACTOR AND SUBCONTRACTORS NOT ELIGIBLE TO PARTICIPATE IN THE OCIP OR IF THERE IS NO OCIP OR IF OCIP IS CANCELLED/TERMINATED:

Excluded Parties or those not eligible to participate in the OCIP (or if the Owner does not implement an OCIP or the OCIP is cancelled or terminated) are required to provide insurance of the prescribed types and minimum amounts set forth in the Contract Documents.

Such insurance requirements are mandatory and are not provided in any manner under the OCIP. The Contractor and Subcontractors are responsible for the cost of insurance requirements referenced in this Section and shall include such costs in their proposals and bid. Such costs are not to be billed separately. The Contractor or Subcontractor may purchase any additional insurance they feel appropriate; however, the cost of such additional insurance will be borne by that party, and shall not be charged to the Owner in any manner.

SECTION 5

ARRANGEMENT AND HANDLING OF THE OWNER CONTROLLED INSURANCE PROGRAM

A) Contractor Portal Enrollment Instructions

Before you begin, please have your Certificate of Insurance, Workers Compensation, General Liability and Excess/Umbrella Liability Policy Declarations and Rating Pages, Experience Mod Rating (EMR) Worksheet (from NCCI or other applicable State Bureau) and Loss History (if Workers Compensation or General Liability coverage is provided on a Loss Sensitive Program) saved and ready to upload during Step 3 of the enrollment process.

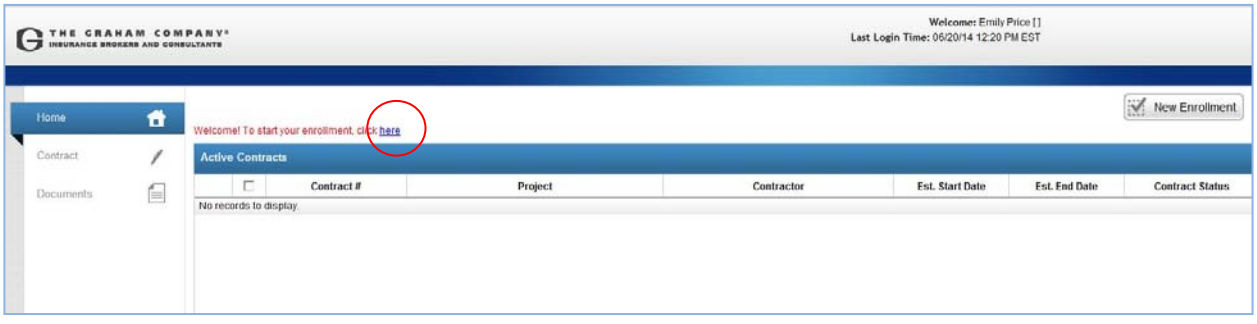
Eligible Subcontractors of every tier will not be permitted to start on-site construction Work until they have submitted the required OCIP enrollment information online and received confirmation of enrollment from The Graham Company. Below are instructions for submitting your enrollment via The Graham Company Contractor Portal (https://grahamco.vuewrapup.com/ContractorPortal/).

You will receive a Welcome Email from The Graham Company containing the above link to the Contractor Portal. Click on the link in the email and a welcome screen will appear prompting you to enter a User Name and Password. In order to set up your User Name and Password click ***Register Me*** located on the bottom right of the screen.

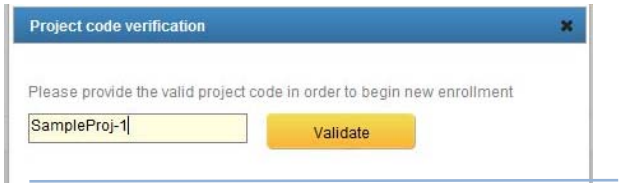
Once registered and logged on you will follow a 3 Step online enrollment process consisting of:

- Step 1: Enrollment – General Information
- Step 2: Insurance Cost Worksheet (ICW)
- Step 3: Document Upload

To submit a new enrollment follow the prompt that says “click here”:



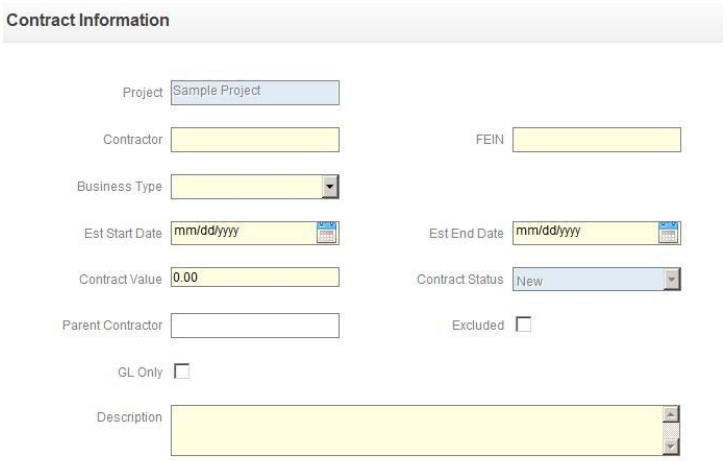
When prompted, enter Project Code provided in your welcome email and click "Validate:"



You are now ready to move on to Step 1.

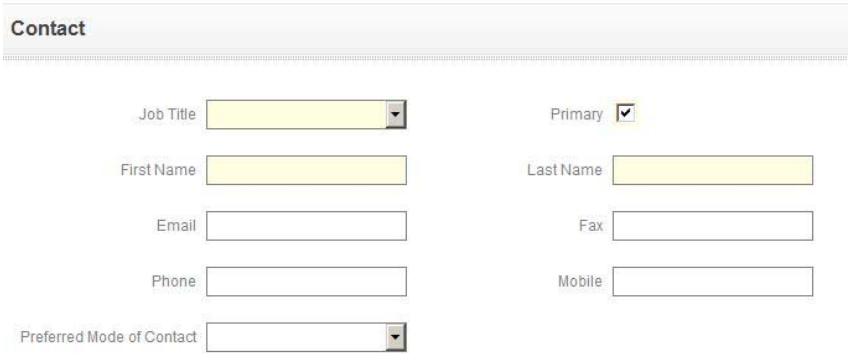
<u>Step 1- ENROLLMENT:</u> There are 5 fields in this step. ***Please note, once you complete Step 1, you cannot go backwards and modify the information. If you made a mistake or need help with any of the steps, please contact Leslie Miraglia at The Graham Company at 215-701-5204.***

a. ***Contract Information***: Please enter your Company's name, FEIN, business type, estimated start and end dates of Work, contract value, contract number, parent contractor (if applicable) and a description of Work. ***All fields shaded yellow are required.***



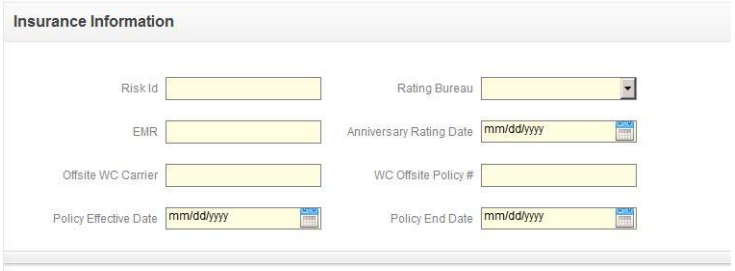
b. ***Address:*** Enter your company's physical address.

c. ***Contact Information:*** Please enter the primary contact person at your company for the OCIP including First and Last Name, Job Title and Email Address. To enter more than one contact person, simply use the "ADD" button on the bottom right of the field.

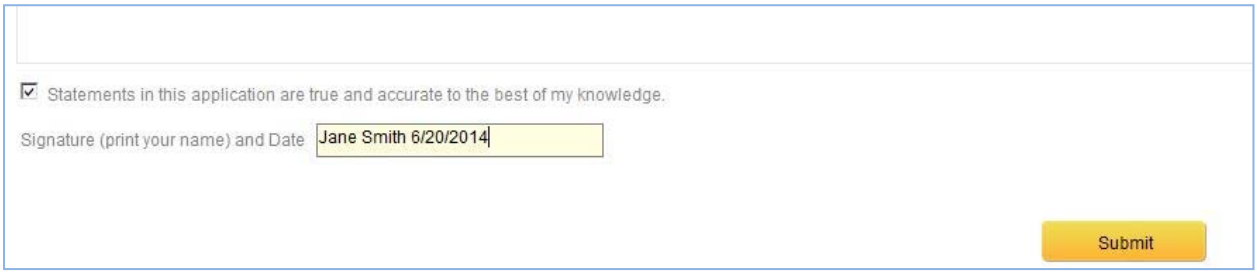


d. ***Estimated Payroll:*** Please enter your estimated labor Hours and Payroll by Workers Compensation Class Code. ***To enter more than one class code in this field, please use the "ADD" button on the bottom right of the field.***

e. ***Insurance Information:*** Please enter your Risk ID, Rating Bureau, Experience Modification Rating, Anniversary Rating Date, Off Site Workers Compensation Carrier, Offsite Workers Compensation Policy Number, Effective Date and End Date.



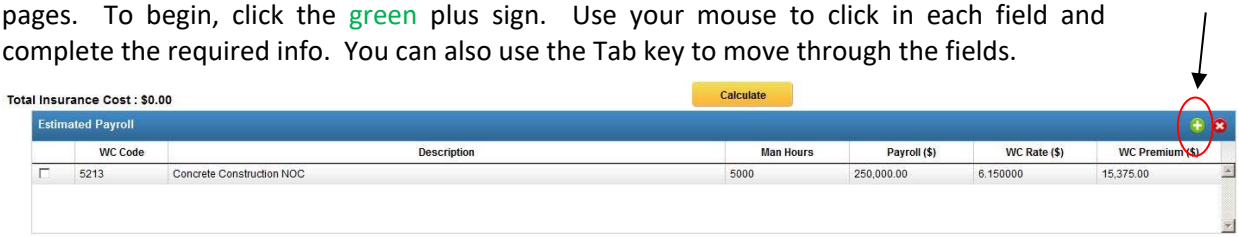
After entering the required information in steps 1.a. through 1.e. you are now ready to Submit. Please review all fields for accuracy, verify your statements are true and correct by checking the box. Then type your electronic signature and click Submit.



You are now ready to move on to Step 2 – the Insurance Cost Worksheet (ICW).

Step 2 - INSURANCE COST WORKSHEET (ICW): In this step you will provide your estimated Insurance Costs related to your work on the Project. Your company's Workers Compensation and General Liability Policy rating pages will help you complete this step. Please note you must complete the ICW in one session. You cannot navigate away from the page and have your information saved.

a. ***Estimated Payroll Field***: In this field you will enter your estimated payroll by class code, the associate hours and Workers Compensation Rate which can be found on your policy rating pages. To begin, click the green plus sign. Use your mouse to click in each field and complete the required info. You can also use the Tab key to move through the fields.



b. ***Workers Compensation Premium Calculation:*** The Workers Compensation Field is templated to reflect the State of Connecticut's standard Workers Compensation rating structure. This is done as a guideline and can be modified based on your policy rating to add additional credits/debits. You will need to enter your EMR factor and any premium discounts, if applicable. Any premium discount must be entered as a negative (-) number.

c. Liability Premium: The Liability Premium Field is also a template containing typical liability rating categories. – Premises and Products/Completed Ops. Please enter your company's specific policy rates and the rating basis (per $1,000 of receipts/per $100 of Payroll).

d. Other Adjustments: This field will calculate estimated overhead and profit on insurance premium using an industry average of 10%.

Other Adjustments

	Description	Rate	$ or %	Total Premium ($)	+ O&P ($)	Total Cost ($)
☐	Overhead & Profit on Insurance Premiums	10.0000	%	0.00	0.00	0.00

Once you have completed all fields, click on the "Calculate" button located at the top of the screen to generate the Total Insurance Cost. Review your figures for accuracy, print your name for Signature and click Submit All on the bottom right of the screen.

You are now ready to move on to Step 3.

Step 3: DOCUMENT UPLOAD In this step, you will need to upload your Certificate of Insurance (completed per the Insurance Manual guidelines), Workers Compensation Policy Declarations and Rating Pages, General Liability Policy Declarations and Rating Pages, Excess Liability Declarations, EMR Worksheet (NCCI or applicable State Bureau) and Loss History if Workers Compensation or General Liability coverage is provided on a Loss Sensitive Program (large deductible, retrospectively rated or self-insured). You will need to have these documents saved on your computer and ready for upload before beginning this step.

a. First, select the document type from the drop down menu. Then click Browse and select your document from its saved location.
b. Click Upload File.
c. Documents will appear in the window below as you upload.
d. If you prefer, you are able to drag and drop documents from your desktop.
e. Repeat until all the required documents are uploaded.

Your enrollment submission is now complete! You will be notified by The Graham Company when your enrollment has been approved or if additional information is required.

B) Identification of Insurance Cost

Enrollees are required to complete enrollment forms and document the cost of insurance related to each awarded Contract, Subcontract and, if specifically required by the Owner, each Change Order related to the Project. Enrollees stipulate that the insurance cost, as identified in the Insurance Cost Information Worksheet (which is incorporated by reference and made a part of their respective Contracts to which the OCIP applies), will be identified as Traditional Insurance Cost, agreed upon but not included within the original bid price or Contract sum, contemporaneously with the execution of such Contracts. All insurance costs for coverage otherwise provided by the Owner under the OCIP will likewise be removed from any Change Orders. If Owner elects to exclude any Enrollee from participating in the OCIP, such Enrollee will provide the insurance required herein and the Traditional Insurance Cost shall remain in such entity's bid price, Contract sum and Change Orders.

Owner will use information presented in the OCIP enrollment process to verify the Traditional Insurance Cost developed by Contractor's entries on the online Insurance Cost Information

Worksheet. An insurance cost deduction rate is determined by dividing the Contractor's verified Traditional Insurance Cost by the Contractor's estimated project payroll. The verified Traditional Insurance Cost and the insurance cost deduction rate will be confirmed to the enrolled Contractor in a deduction rate verification letter. The insurance cost deduction rate is the ratio of verified Traditional Insurance Cost to the enrolled Contractor's estimated payroll.

C) Notice of Contract Award

Upon a Contract being awarded to any Subcontractor, the Contract awarding party is to complete and forward a Notice of Contract Award (Form 4) to The Graham Company, Attn: Leslie Miraglia (e-mail address: lmiraglia@grahamco.com, or kilgarriff_unit@grahamco.com and fax number: 215-599-9936).

D) Attachment of Coverage

The Owner has arranged to provide the insurance identified within Section 2 of this Manual for the Contractor and eligible Subcontractors for their Work to be performed at the Jobsite.

Note: Enrollment into the OCIP is required but not automatic. The Contractor and eligible Subcontractors must complete the enrollment process identified within Section 9 of this Manual. Once enrolled, the Contractor or Subcontractor will receive notification of acceptance from The Graham Company and coverage under the OCIP will begin. Access to the Jobsite will not be permitted until the enrollment process is complete.

A FAILURE TO COMPLETE THE OCIP ENROLLMENT PROCESS PRIOR TO THE START OF WORK MAY EXCLUDE THE PARTY FAILING TO DO SO FROM OCIP INSURANCE COVERAGE. IF EXCLUDED, THE OWNER WILL NOT BE RESPONSIBLE FOR OR REIMBURSE ANY ADDITIONAL AMOUNTS FOR INSURANCE COSTS.

E) OCIP Enrollment Forms

To be considered for enrollment in the OCIP the Contractor and each Subcontractor is required to submit the following documentation to The Graham Company. Copies of the any required forms, including instructions on how they are to be completed can be found in Section 9 of this Manual.

Form 1: Insurance Cost Worksheet (to be completed and submitted with bid)

Form 2: Enrollment Form (to be completed online)

Note: Any incomplete or inaccurate Insurance Cost Worksheet and online enrollment cost information may be corrected by Owner. When making such corrections Owner will rely upon state issued Workers Compensation rates, industry standard rates and the Owner's judgment to estimate Contractor's insurance cost rate.

Form 3: Required Certificate of Insurance

Prior to the date on which the Contractor commences its Work, the Contractor must furnish a Certificate of Insurance to The Graham Company evidencing coverage required by Contract Documents and this Manual.

THE CERTIFICATE OF INSURANCE MUST BE PROVIDED TO AND APPROVED BY THE OCIP ADMINISTRATOR PRIOR TO THE START OF WORK.

Upon receipt and acceptance of the above, The Graham Company will send correspondence confirming enrollment into the Program. Accompanying this confirmation email will be a Certificate of Insurance verifying the coverage and applicable Claims Reporting Information. A copy of the Owner's Safety Guidelines will be made available in the Contractor Portal along with the separate Workers Compensation Policy as required by State Law, once issued.

F) Notice of Work Completion Form

Upon completion of the Enrollee's portion of the Work, the Contractor and Subcontractors are to submit a Notice of Work Completion. This form shall be completed online. Except for completed operations coverage and unless otherwise provided in this Manual, all insurance furnished by Owner under the OCIP will cease for Enrollees upon completion of such Enrollee's portion of the Work.

G) Program Audit

The Owner or its designee will at all times have the right to access, inspect and audit all Enrollees' records and data, electronic or otherwise, relating to costs for coverages provided by the Owner, payrolls, employee work-hours and other factors determinative of the cost of the OCIP. Enrollees will promptly respond to any inquiries of the Owner or its designee arising out of any such inspection or audit. The Owner will be entitled to all discounts, refunds, reduced rates, and other premium credits applicable to such coverages. Enrollees will notify the Owner of subsequent changes to their policies due to renewal, endorsement or change in underwriters. The Contractor and all Subcontractors for whom insurance is provided by the OCIP, are required to maintain the above described records. These records are needed to:

1. provide the information needed to calculate the insurance premium to be paid by the Owner for the Work performed at the Jobsite by the Contractor or Subcontractors as appropriate; and
2. assist the insurer in filing information to the Workers Compensation Rating Bureau for inclusion into the calculation of the applicable party's Experience Modification.

H) Payroll Reports

Enrolled Contractors and Subcontractors are required to submit monthly payroll reports through The Graham Company's Contractor Portal. Reports are due by the 5th of each month for the prior month's Work. In addition to aggregate monthly hours and wages, enrolled Contractors and Subcontractors will also be required to break out hours and wages among the following EEO categories of employees: (1) Minority; (2) Female; (3) Apprentice; (4) Apprentice, 1st Year; and (5) New Haven Resident.

New Haven Resident Employee information must also include details such as home address, hours, applicable Trade Union, Trade Union Status and Tenure.

Only the payroll of employees who perform Work at or emanating directly from the Jobsite are to be included in the audit.

The following are examples of non-Jobsite employees whose payroll are not to be included:

(1) Permanent yard and shop employees away from the Jobsite.

(2) Equipment maintenance employees not exclusively engaged in servicing equipment at the Jobsite (even though working on equipment which may used exclusively on the Jobsite), and who, as part of their regular duties, are not assigned to the Project.

(3) Executive supervisors who are not permanently assigned to the Project.

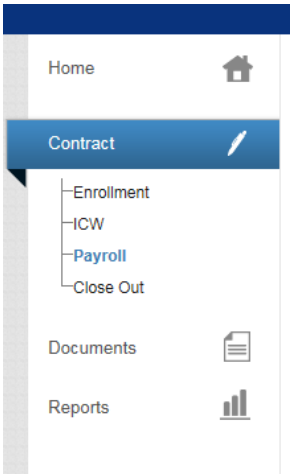
(4) Headquarters and administrative staff not performing their principal duties at the Jobsite.

An insurance company auditor may visit the Contractor's or Subcontractor's office to collect payroll information on an annual basis and at the conclusion of the Work.

I) Payroll Classification and Limits

Payroll Classification - The rules and regulations of the Connecticut Compensation Rating Bureau shall govern all classification assignments and the definition of the payroll to be included in the audit. The extra pay for overtime Work shall be excluded with the payroll on which premium is computed.

J) Contractor Portal Payroll Reporting Instructions

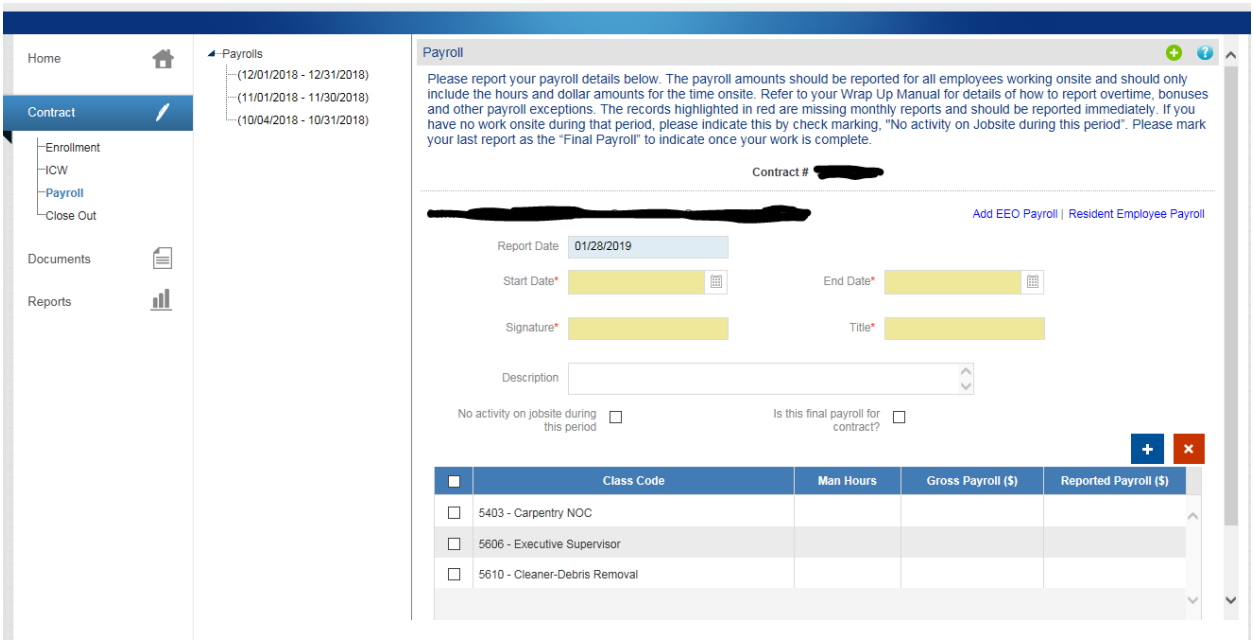


1. Log onto the Contractor Portal at https://grahamco.vuewrapup.com/ContractorPortal/ using your established user name and password.

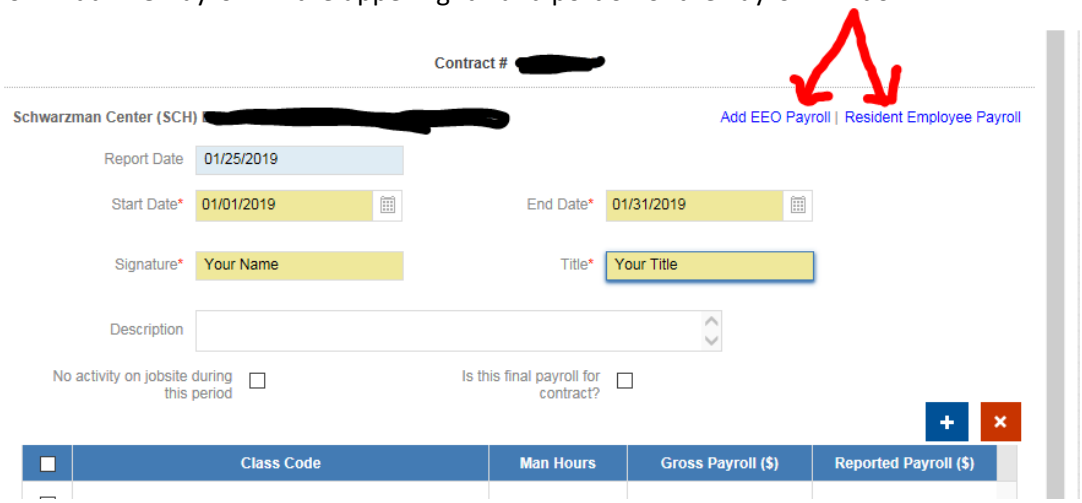
2. Check the box to the left of your contract number.

3. Navigate to the menu on the left-hand side and click on "Payroll".

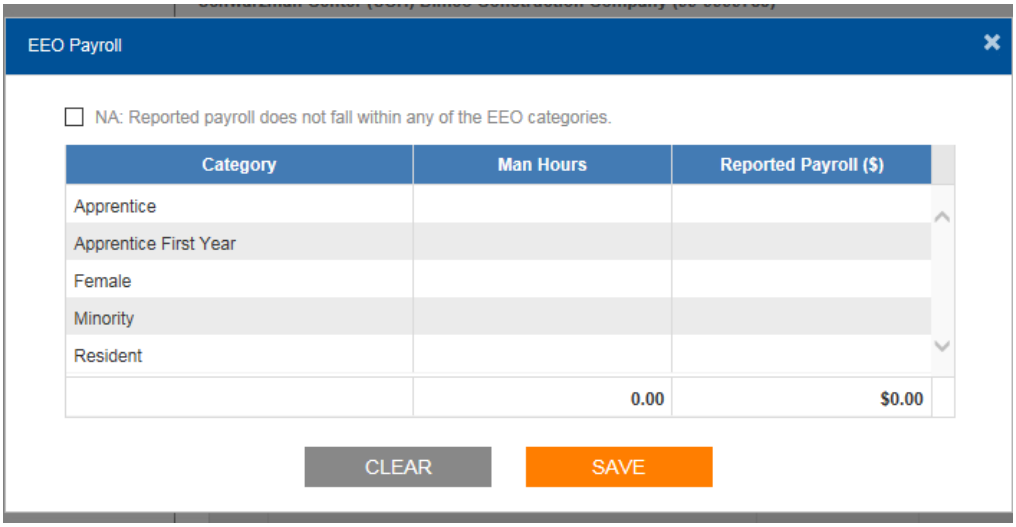
4. Once on the Payroll screen you will see the range of dates for which you must report in red on the left. Click on the date then move to the table below where 1 or more Workers Compensation class codes are listed. (This information is based on your estimates at enrollment.) Simply click in the fields for hours and payroll to type your figures for each class code.



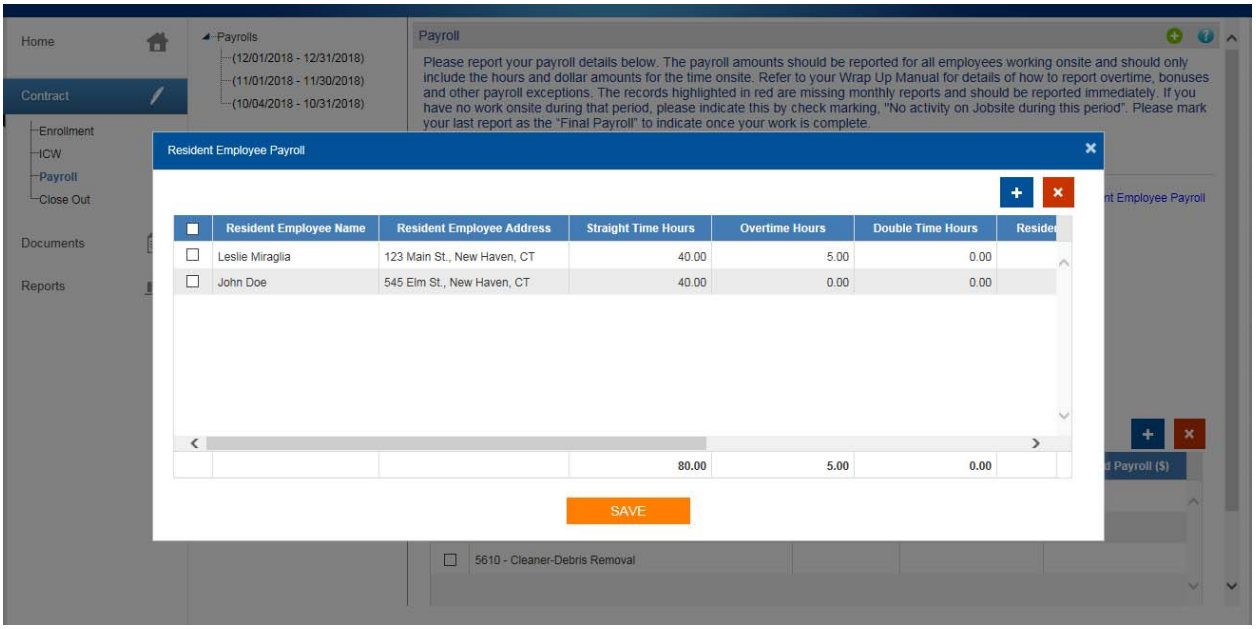
Your monthly reports must include information regarding various EEO Categories. To add please click on "Add EEO Payroll" in the upper right-hand portion of the Payroll Window.



The window below will pop up. Please fill in all appropriate fields. If there are 0 hours/dollars for a particular category, please fill in 0. Then click "SAVE".



You are required to provide additional information for your New Haven Resident Employees including name, address, hours, payroll, union affiliation and status. To do so click on "Resident Employee Payroll" and the window below will pop up. To add an employee, use the plus (+) icon. Your entry of individual New Haven residents will carry over to the next month. Once you have entered all the required information click "SAVE".



5. Review all the information you've entered, **type your signature** and click Submit. Please note, if you would like a print out of your monthly report, you can do so in the Reports section of the portal.

SECTION 6

PROJECT SAFETY REQUIREMENTS

The Contractor and Subcontractors shall actively support, participate in and be responsible for compliance with all safety requirements included within the Project Safety Plan and Safety Guidelines.

OWNER'S INSURANCE REPRESENTATIVES

The Owner's Insurance Representative will provide safety services on behalf of Owner and some or all insurance companies involved in the OCIP. The Contractor and all Subcontractors agree that the Owner's Insurance Representative shall at all times be immune from liability for providing such services. The Contractor and all Subcontractors shall waive any and all defenses to or limitations in connection with the application to Owner's Insurance Representatives of any law limiting the liability of agents, employees or service contractors acting on behalf of an insurance company proving services which reduce the likelihood of injury or loss.

SECTION 7

ACCIDENT REPORTING AND CLAIMS PROCEDURES

The OCIP Administrator has developed very specific accident reporting and claims procedures. It is extremely important that the Contractor and all Subcontractors follow these procedures as well as the Accident Reporting Procedures in the Safety Guidelines when accidents occur.

A. Immediate Reporting Of Accidents/Claims

All known accidents and occurrences, however minor, must be reported (the reporting procedures for the different types of claims are addressed below) within 24 hours. Without adequate investigations immediately following accidents, claims are very difficult to defend or fully investigate later. **Failure to report a known claim within 24 hours of an occurrence will result in a $500 fine assessment. This fine will be issued through a Non-Negotiable Deduct Change Order or other means at the Owner's discretion.**

B. Emergency Claims Service

In the event of an emergency claim, please call The Graham Company at (215) 567-6300, 24 hours a day, 7 days a week for emergency claims service. If calling after hours, the caller will receive instructions on how to reach The Graham Company's On-Call Emergency Claim Coordinator. Examples of emergency claims are: fatalities; severe injuries; floods; fire losses; large dollar losses; irate claimants; accidents involving spills/pollutants; suspected fraudulent claims; and incidents which could erupt into larger losses if not tended to immediately.

C. Workers Compensation Claims Procedures

(1) ***Medical Treatment***

The injured employee's foreman shall see that appropriate first aid and treatment is administered promptly. Foremen should immediately accompany injured employees to the Jobsite medical facility. For emergency/critical care and the rare circumstances where treatment cannot be rendered at the Jobsite medical facility, the following procedures will apply. "Treatment" for this purpose doesn't necessarily mean "medical treatment" for purposes of OSHA recordkeeping as defined in 29 CFR 1904.

(a) Non-Emergency Medical Treatment

A Panel of Physicians has been established for medical treatment in the event of a work-related accident that cannot be treated at the Jobsite medical facility. Panel of Physicians Posting Notices (Form 8) specify where employees should go for medical treatment in these situations. The Contractor shall prominently display these notices in areas frequented by employees.

If an employee claims to have suffered a work-related injury or illness, the employer shall provide the employee with a Treatment Authorization Form (Form 9). The employee must present this Form 9 to the medical facility (if applicable). The form also provides the information necessary to call the employer following the examination to advise when the employee may return to work.

(b) Emergency/Critical Care Treatment

In the event of an emergency or serious accident requiring notification of Emergency Medical Services involving an employee, enlist the immediate help of the Jobsite medical facility and take the employee to the nearest hospital emergency room. This should be Yale New Haven Hospital, Saint Raphael Campus at 300 Orchard Street in New Haven, CT or Yale New Haven Hospital at 20 York Street in New Haven, CT. Any question of whether or not an injury is serious and involves emergency treatment should be resolved in favor of the employee being taken to the emergency room.

Any follow-up care subsequent to the initial emergency room visit should be rendered at the Jobsite medical facility or by a provider from the Panel of Physicians. The Jobsite medical facility is Yale New Haven Health, Occupational Medicine and Wellness Services, 175 Sherman Avenue, 5th Floor, New Haven, CT.

(c) After Hours/Weekend Treatment

The Jobsite medical facility will be available during the work day and the providers listed on the Panel of Physicians have office hours every day of the week including Saturday and Sunday.

(2) ***Medical Follow-Up Care***

The Jobsite medical facility and the providers from the Panel of Physicians are required to call the Contractor or Subcontractor following each office visit, to provide a current status on the employee's condition and an evaluation of whether the employee is able to return to work. All efforts should be made to return an employee to work as soon as they are physically able.

(3) ***Prescription Services***

If the employee needs injury related prescriptions, that employee should be provided with the Temporary Prescription Services ID (Form 10) which lists many of the independent pharmacies included in the network of pharmacies. No identification cards are required to be presented by the employee to obtain a prescription.

(4) ***Mailing of Medical Bills***

The Contractor or Subcontractor shall send medical bills to Sedgwick CMS.

For medical bill submission, please use the following mailing address:

Sedgwick CMS

P.O. Box 14498

Lexington, KY 40512-4498

(5) ***Workers Compensation Claim Reporting***

The Contractor or Subcontractor will be able to report Workers Compensation Claims by email using a designated email address. Employers should report directly to Sedgwick CMS unless previously agreed to for a specific project. Workers Compensation claims should be reported by the end of the workday.

The person designated to report Workers Compensation claims should email Sedgwick CMS at 9391yaleuniversity@sedgwick.com. Please provide the operator with the Contractor's or Subcontractor's policy number and Contract Number. This information is listed in the caption of the enrollment letter. Sedgwick CMS will file the original Employer's First Report of Occupational Injury or Illness with the State of Connecticut Workers Compensation Commission and the intake service will provide a copy to the Contractor or Subcontractor, its employee and The Graham Company.

The Contractor or Subcontractor shall report immediately an accident resulting in serious injury or death by telephone to Sedgwick CMS via email at 9391yaleuniversity@sedgwick.com and to Kimberly E. Sharkey at The Graham Company at (215) 701-5278. The Contractor or Subcontractor shall send any written reports to Sedgwick CMS and The Graham Company immediately.

The insurance company's contact information:

Sedgwick CMS

P.O. Box 14519

Lexington, KY 40512-4151

Toll Free: 800-526-3721

Workers Compensation Claim Reporting: 9391yaleuniversity@sedgwick.com

(6) ***Modified Duty Work***

The Contractor or Subcontractor shall promptly return an injured employee to full or modified duty work (as their physical condition permits) as soon as it is advised by the employee's treating physician of the employee's ability to return to work. Upon such notification, the Contractor or Subcontractor shall immediately return such injured employee to work whether or not a job is immediately available and whether or not such work is available on the Project. **Failure to do so will result in a fine assessment to the Contractor or Subcontractor of $1,500 weekly until such time as the released injured employee is returned to work. This fine will be issued through a Non-Negotiable Deduct Change Order or other means at the Owner's discretion.**

(7) ***Questions Concerning Workers Compensation Claims***

Questions concerning Workers Compensation claims should be addressed to the insurance company's claims representative assigned to handle the claim. The telephone number of the claims office for the Project is 1-800-526-3721. The claims representative will identify himself/herself within twenty-four (24) hours after he/she receives notice of the claim.

If the Contractor or Subcontractor is uncertain as to who the claims representative is on a particular claim or it has more general questions as to the operation of the claim or claims process, please call Kimberly E. Sharkey at The Graham Company at (215) 701-5278.

If the Contractor or Subcontractor requires a loss run or would like to participate in a claims review meeting, please notify Kimberly E. Sharkey at The Graham Company at (215) 701-5278.

D. Commercial General Liability Claims Procedures

The Subcontractor shall immediately notify the Contractor of any Commercial General Liability claims (claims involving injuries to persons other than employees or damage to property other than damage to the Work itself) by its employees or Subcontractors. The Contractor shall then compile all available information regarding the loss, complete the Acord Form (Form 11) for the Project and immediately send it by fax or email to:

The Graham Company Claims Services Department
The Graham Building
One Penn Square West
Philadelphia, PA 19102
Attention: Kimberly E. Sharkey, CPCU, AIC
Vice President
Fax: (215) 525-0256
Email: ksharkey@grahamco.com

All claims involving significant damage, serious injuries or death shall be reported by telephone to Kimberly E. Sharkey at (215) 701-5278 and followed up by the completion and forwarding of the Acord Form.

It is vital that:

a. all evidence related to a claim be retained and identified to the insurance company representative investigating the claim;

b. no one speak to or show evidence to anyone other than a duly authorized representative of the insurance company, The Graham Company, Contractor, Subcontractor or Owner;

c. all witnesses to the accident are noted along with addresses, daytime and home telephone numbers by which to contact them; and

d. all damages are fully documented (either by photograph, invoice, etc.).

All questions concerning Commercial General Liability Claims should be directed to Kimberly E. Sharkey at The Graham Company at (215) 701-5278.

E. Legal Documents

It is extremely important that all lawsuits or Writs of Summons be forwarded to The Graham Company immediately upon receipt. All lawsuits and other legal documents are to be faxed or emailed to The Graham Company's Claims Services Department, attention Kimberly E. Sharkey. When forwarding lawsuits to The Graham Company, please provide the exact date that the Contractor or Subcontractor was served with the papers, and how the service was made (i.e., certified mail, marshal, etc.). The failure to promptly forward lawsuits to The Graham Company may result in the loss of insurance coverage for the claim.

All subsequent questions and correspondence received by the Contractor or Subcontractor relative to claims (other than medical bills), including lawsuits or other legal documents, must be immediately referred by the Contractor or Subcontractor to the insurance company and The Graham Company indicating that such questions and correspondence apply to the Project. In addition to the fax or email, the Contractor or Subcontractor shall send all legal documents by registered mail, return receipt requested.

NAMES AND EMAIL ADDRESSES FOR CLAIMS REPORTING

A. Workers Compensation

Company: AXA XL/Sedgwick CMS

Lost Time Adjuster: Catherine Boyer
Phone: (501) 954-2265
Email: catherine.boyer@sedgwick.com

Medical Only Adjuster: Jason Castille
Phone: (469) 624-1043
Email: jason.castille@sedgwick.com

Administrator: Kim Sharkey
The Graham Company
Phone: (215) 701-5278
Email: ksharkey@grahamco.com

B. General Liability

Company: AXA XL/Sedgwick CMS (Greenwich Insurance Company)

Complex Adjuster: Heather Fischer
Phone: (331) 684-9485
Email: heather.fischer@sedgwick.com

All Other Adjuster: Nicole DeYoung
Phone: (331) 684-9429
Email: nicolerenee.deyoung@sedgwick.com

Administrator: Kim Sharkey
The Graham Company
Phone: (215) 701-5278
Email: ksharkey@grahamco.com

SECTION 8

FORMS AND ONLINE ENROLLMENT INSTRUCTIONS

This section contains the required forms needed to administer the OCIP.

IT WILL BE THE RESPONSIBILITY OF THE CONTRACTOR AND EACH SUBCONTRACTOR TO SEE THAT EACH OF ITS ELIGIBLE SUBCONTRACTORS COMPLETES THE ENROLLMENT PROCESS. FAILURE OF THE CONTRACTOR OR SUBCONTRACTOR TO COMPLETE THE ENROLLMENT PROCESS COULD RESULT IN PAYMENTS TO THE CONTRACTOR OR SUBCONTRACTOR BEING WITHHELD.

This section contains the following forms:

ENROLLMENT:
Form 1: Insurance Cost Worksheet
Form 1a: Loss Funding Calculation Worksheet
Form 1b: Insurance Cost Summary
Form 4: Notice of Contract Award
Form 5: Notice of Work Completion
Form 7: Sample Certificates of Insurance – to be provided by Enrollees and Non-enrolled Subcontractors

For assistance in completing the OCIP enrollment process, please contact The Graham Company:
Leslie Miraglia – Phone #215-701-5204
John Kilgarriff – Phone #215-701-5425

OTHER INCLUDED FORMS:
Panel of Physicians Posting Notice (Form 8)
Authorization for Treatment Form (Form 9)
Temporary Prescription Services ID (Form 10)
Acord 1 – Commercial General Liability Loss Notice (Form 11)

For assistance in completing these forms, please contact The Graham Company:
Kimberly E. Sharkey – (215) 701-5278

OWNER CONTROLLED INSURANCE PROGRAM
INSURANCE COST INFORMATION WORKSHEET

All Contractors, Subcontractors, and Sub-subcontractors of every tier, are required to complete this worksheet and submit as part of your bid.

Note: It is suggested that you examine your current Policies and contact your Insurance Broker before answering the following questions.

Project: _____

1. Contractor/Subcontractor/Sub-subcontractor: _____
2. Address:_____
3. Federal ID#:_____ 3a. Work Comp Bureau ID#:_____
4. Telephone Number:_____ Fax:_____ E-Mail:_____
5. Contact Name:_____

Bid Package (Name and Number): _____

6a. Contract Amount: $_____ 6b. Amount of Self Performed Work: $_____

7. Description of Work:_____
8. Awarding Contractor: _____
9. Claim Retention or Deductible Amounts (if greater than $5,000): WC_____ GL_____

A. Workers Compensation Estimated Payrolls/Premiums (attach separate sheet if necessary):

(1) Workers Compensation Classification(s)	(2) WC Class Code(s)	(3) Man-hours by Class Code	(4) Estimated Payroll	(5) Workers Compensation Premium Rate	(6) Workers Compensation Premium
Totals=>>					$

MODIFICATIONS TO WORKERS COMPENSATION PREMIUM		FACTOR	CHARGE	PREMIUM
A.	Estimated Total Premium (All Class Codes)			
B.	Increased Limit Factor-ILF (x A)			
C.	Experience Modification Factor or Merit Rating Credit (A+B) X C			
D.	Deviation (x C)			
E.	Construction Credit (x C)			
F.	Standard Premium (C+D+E)			
G.	Premium Discount (x C)			
H.	Deductible Credit (x C)			
I.	Scheduled Credit (x C)			
J.	Terrorism Risk Insurance Act			
K.	Other Applicable Factor			
L.	Second Injury Fund			
M.	Work Comp Funds Assessment			
N.	State Specific Surcharge			
O.	WC Loss Fund* (Form 1A – line e)			
P.	**TOTAL WORKERS COMPENSATION PREMIUM**			

**if WC is provided under large deductible, retrospectively rated or other loss sensitive program, contractor is required to compete Form 1A to determine WC Loss Fund for the bid.*

B. Commercial General Liability

Rating Basis: ☐ Payroll ☐ Contract Value ☐ Other: _____
☐ Per $100 ☐ per $1,000

GL Classification	GL Code	GL Rate	GL Payroll/Contract Value	Premium
			$	$
			$	$
		TOTAL:	*(B1)* $	*(B2)* $

C. Commercial Umbrella/Excess Liability

Classification	Code	Rate	Payroll/Contract Value	Premium
		25% of GL Premium (B2 above) or policy rate	$	$
			$	$
		TOTAL:	*(C1)* $	*(C2)* $

D. Builders Risk and Installation Floater

Rating Basis: ☐ Per $100 Contract Value ☐ Per $1,000 Contract Value ☐ Other: _____

Rate: _____ (D1) Contract Value: _____ (D2) Premium: _____ (D1) x (D2)

E. Total Insurance Premiums (A+B+C+D) **$_____**

F. Overhead & Profit on Insurance Premiums: 10 (F1) % **$_____** (F1) x E

G. Total Insurance Credit (E+F): **$_____**

Contractor/Subcontractor Insurance Credit Rate: (G/Estimated Payroll) _____

H. ADDITIONAL DOCUMENTS REQUIRED:

The following information must be provided along with this form:

a. Work Comp declaration page and rating pages
b. Experience Modification Worksheet from NCCI (or applicable) Bureau
c. General Liability declaration page and rating pages
d. Umbrella Liability declaration page and rating pages
e. 5 Years of GL and WC loss runs for any policy with a deductible / retention greater than $2,500.
f. 5 years of audited payrolls and GL exposures (payroll/receipts) for applicable policies with deductibles greater than $5,000
g. Form 1B for any contractor who has subcontracted to work to other contractors or plans to subcontract work.

WARRANTY
(If Enrolled in OCIP)

Regarding Workers Compensation, General Liability and Umbrella/Excess Liability: These coverages, as stated in the Contract Documents are provided by the Owner. The undersigned agrees and warrants:

1. The Contractor certifies that they have identified in their bid the Contractor's cost for the Workers' Compensation, General Liability and Umbrella/Excess Liability Coverages that are being provided and paid for by the Owner. The Contractor gives the Owner authority to audit its records for verification and to adjust the "Total Insurance Credit" and "Contractor Insurance Credit Rate".
2. It is the Contractor's responsibility to notify their insurance carrier as to the existence of an Owner Controlled Insurance Program for this project and to amend their insurance policies accordingly.
3. The statements in this insurance application are true to the best of my knowledge.
4. The cost of the premiums for the non-OCIP insurance specified in the Contract will be paid for by the Contractor.
5. Any and all returns of premium, dividends, discounts or other adjustments to any OCIP policy is assigned, transferred and given absolutely to the Owner. This assignment pertains to the OCIP policies as now written and as subsequently modified, rewritten or replaced, including any additional amounts or coverages as a result thereof. Rights of cancellation of all insurance policies provided to Contractor are also assigned to the Owner. This assignment is only valid for insurance policies whose premiums have been paid by the Owner on behalf of such Contractors.

Date:_____ Name:_____
(please print)

Title:_____ Signature:_____

OWNER CONTROLLED INSURANCE PROGRAM
LOSS RATE CALCULATION WORKSHEET

Note: This is to be completed if contractor maintains WC or GL coverage subject to deductible in excess of $5,000

Project: _____

1. Contractor/Subcontractor/Sub-subcontractor: _____
2. Address:_____
3. Federal ID#:_____ 3a. Work Comp Bureau ID#:_____
4. Telephone Number:_____ Fax:_____ E-Mail:_____
5. Contact Name:_____

Bid Package (Name and Number): _____

6a. Contract Amount: $_____ 6b. Amount of Self Performed Work: $_____

7. Description of Work:_____
8. Awarding Contractor: _____
9. Claim Retention or Deductible Amounts (if greater than $5,000): WC_____ GL_____

I. WC Loss Rate Calculation *(if Applicable)*

Description	2010-11	2011-12	2012-13	2013-14	2014-15	Total
Gross WC Losses[1]						
Net WC Losses[2]						
Loss Development Factor (LDF)	1.20	1.30	1.40	1.75	2.50	
Adjusted Net WC Losses[3] *(= Net WC Losses x LDF)*						(a)
Payroll[4]						(b)
					WC Loss Rate (a / b)	(c)
					Projected Payroll for Project (from Form 1 – line A4)	(d)
					WC Loss Fund (c x d)	(e)

1. List total incurred losses for each of the past 5 policy periods.
2. Each loss in excess of the applicable deductible shall be limited to determine "Net WC Losses". Supporting carrier generated loss runs valued within 60 days of bid date must be provided.
3. For each policy period, multiply "Net WC Losses" by LDF, enter result. Sum and enter result as (a).
4. Enter total field payroll for each policy period. Sum and enter result as (b)

II. GL Loss Rate Calculation (if Applicable)

Description	2010-11	2011-12	2012-13	2013-14	2014-15	Total
Gross GL Losses[1]						
Net GL Losses[2]						
Loss Development Factor (LDF)	1.20	1.30	1.40	1.75	2.50	
Adjusted Net GL Losses[3] *(= Net GL Losses x LDF)*						(a)
Construction Value (CV) / Payroll[4]						(b)
					GL Loss Rate (a / b)	(c)
					Projected CV/Payroll for Project (from Form 1 – line B1)	(d)
					GL Loss Fund (c x d)	(e)

1. List total incurred losses for each of the past 5 policy periods.
2. Each loss in excess of the applicable deductible shall be limited to determine "Net GC Losses". Supporting carrier generated loss runs valued within 60 days of bid date must be provided.
3. For each policy period, multiply "Net WC Losses" by LDF, enter result. Sum and enter result as (a).
4. Enter total field payroll or CV as appropriate for each policy period. Sum and enter result as (b)

Fax To: Leslie Miraglia
The Graham Company
215-599-9936

E-Mail To: kilgarriff_unit@grahamco.com

Mail To: Leslie Miraglia
The Graham Company
The Graham Building
One Penn Square West
Philadelphia, PA 19102

OWNER CONTROLLED INSURANCE PROGRAM
LOSS RATE CALCULATION WORKSHEET

Note: This form is to be completed by any contractor who intends to subcontract any portion of the work to be performed under contract

Project: _____

1. Contractor/Subcontractor/Sub-subcontractor: _____
2. Address:_____
3. Federal ID#:_____ 3a. Work Comp Bureau ID#:_____
4. Telephone Number:_____ Fax:_____ E-Mail:_____
5. Contact Name:_____

Bid Package (Name and Number): _____

6a. Contract Amount: $_____ 6b. Amount of Self Performed Work: $_____

7. Description of Work:_____
8. Awarding Contractor: _____

	Contracting Parties & Trades	**Proposed Subcontract Amount**	**Estimated Man-hours**	**Estimated Payroll**	**Initial Insurance Cost**
Subcontractors which have been identified					
Additional Trade Packages *for which subcontractor has not been identified*	List by Trade or Function:				
Total for Contract:				a	b
Composite Insurance Cost Rate for Contract: (a ÷ b x 100)					

FORM 4

OWNER CONTROLLED INSURANCE PROGRAM

NOTICE OF CONTRACT AWARD

We have awarded a contract to the following Contractor/Subcontractor:

1. Project Name: _____
2. Subcontractor Name:_____
3. Address:_____
4. Phone Number:_____
5. Contact Person: _____
6. E-Mail Address:_____
7. Estimated Start Date:_____
8. Estimated Completion Date:_____
9. Assigned Contract Number:_____
10. Description of Work:_____
11. Contract Amount:_____
12. Awarding Contractor:_____
13. Awarding Contractor Contact Person: _____

Prior to the Approved Contractor or Subcontractor being permitted on-site, The Graham Company must receive their Enrollment Forms.

Fax To: Leslie Miraglia
The Graham Company
215-599-9936

E-Mail To: Leslie Miraglia
The Graham Company
E-Mail: kilgarriff_unit@grahamco.com

FORM 5

YALE UNIVERSITY
OWNER CONTROLLED INSURANCE PROGRAM
NOTICE OF WORK COMPLETION

1. Contractor Name and ID#: _____

2. Project: _____

3. Contract #: _____

4. Work Performed: _____

5. Date work completed: _____

_____
Signature

Fax To: Leslie Miraglia
The Graham Company
215-599-9936

Mail To: Leslie Miraglia
The Graham Company
The Graham Building
One Penn Square West
Philadelphia, PA 19102
E-Mail: kilgarriff_unit@grahamco.com

Enrolled Contractors

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
INSURED	INSURER A :	
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	[X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [X] PRO-JECT [ ] LOC [ ] OTHER:	X	X	[Applicable policy number]	TBD	TBD	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG 	$ 1,000,000 $ $ $ 1,000,000 $ 2,000,000 $ 2,000,000 $
	AUTOMOBILE LIABILITY [X] ANY AUTO [X] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS [ ]	X	X	[Applicable policy number]	TBD	TBD	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ 1,000,000 $ $ $ $
	[X] UMBRELLA LIAB [X] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $	X	X	Applicable policy number]	TBD	TBD	EACH OCCURRENCE AGGREGATE 	$ 5,000,000 $ 5,000,000 $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N [ ] **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A	X	[Applicable policy number]	TBD	TBD	[X] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 500,000 $ 500,000 $ 500,000
	Contractors Pollution Liability		X	[Applicable policy number]	TBD	TBD	$5,000,000 per occurrence/aggregate (Aggregate - per project)	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

RE: Project Name - Contract Number

Yale University, it's subsidiaries, affiliated companies, and their respective directors and officers, trustees, representatives, agents and employees are added as additional insureds on the General Liability (per ISO endorsements CG20101001/CG20371001 or equivalent), Business Auto and Umbrella Liability policies. Coverage provided to the additional insureds shall apply on a Primary and Non-Contributory basis. Prior to loss, a Waiver of Subrogation is provided on the above referenced Commercial General Liability, Business Auto, Workers' Compensation and Employers Liability and Pollution Liability policies naming Yale University, subsidiary and affiliated companies, and their respective directors and officers, trustees, and employees as protected parties. General Liability and Workers Compensation coverage apply for off-site operations of Insured. All other referenced policies apply to both on-site and off-site operations of the Insured.

CERTIFICATE HOLDER

Yale University
Office of the General Counsel
2 Whitney Avenue, 6th Floor
New Haven, CT 06511

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Non-Enrolled Contractors

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
INSURED	INSURER A :	
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	[X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [X] PRO-JECT [ ] LOC [ ] OTHER:	X	X	[Applicable policy number]	TBD	TBD	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG 	$ 1,000,000 $ $ $ 1,000,000 $ 2,000,000 $ 2,000,000 $
	AUTOMOBILE LIABILITY [X] ANY AUTO [X] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS	X	X	[Applicable policy number]	TBD	TBD	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ 1,000,000 $ $ $ $
	[X] UMBRELLA LIAB [X] OCCUR EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $	X	X	Applicable policy number]	TBD	TBD	EACH OCCURRENCE AGGREGATE 	$ 5,000,000 $ 5,000,000 $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N [ ] **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A	X	[Applicable policy number]	TBD	TBD	[X] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 500,000 $ 500,000 $ 500,000
	Contractors Pollution Liability		X	[Applicable policy number]	TBD	TBD	$5,000,000 per occurrence/aggregate (Aggregate - per project)	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

RE: Project Name - Contract Number

Yale University, it's subsidiaries, affiliated companies, and their respective directors and officers, trustees, representatives, agents and employees are added as additional insureds on the General Liability (per ISO Endorsements CG20101001/CG20371001 or equivalent), Business Auto and Umbrella Liability policies. Coverage provided to the additional insureds shall apply on a Primary and Non-Contributory basis. Prior to loss, a Waiver of Subrogation is provided on the above referenced Commercial General Liability, Business Auto, Workers Compensation and Employers Liability and Pollution Liability policies naming Yale University, subsidiary and affiliated companies, and their respective directors and officers, trustees, and employees as protected parties. The above referenced polices apply to both on-site and off-site operations of the Insured.

CERTIFICATE HOLDER

Yale University
Office of the General Counsel
2 Whitney Avenue, 6th Floor
New Haven, CT 06511

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Your employer has selected Yale-New Haven Hospital's Occupational Health Plus/ Worker Health Solutions to provide treatment for workplace injuries.

Workplace Injuries

These two trusted and outstanding health service providers have joined forces and are available at four (4) convenient locations:

BRANFORD
84 North Main Street, Bldg 1, 2nd Floor
Branford, CT 06405
Phone: (203) 789-5195 • **Fax**: 203-867-5223
Hours: Monday – Friday 8:30 am – 5 pm

EAST HAVEN
317 Foxon Road, East Haven, CT 06513
Phone: (203) 466-5600 • **Fax**: (203) 466-5630
Hours: Monday – Friday 8 am – 7 pm;
Saturday 8 am – 3:30 pm; Sunday 9 am – noon

HAMDEN
2080 Whitney Avenue, Suite 150, Hamden, CT 06518
Phone: (203) 789-6240 • **Fax**: (203) 789-6243
Hours: Monday – Friday 8:30 am – 5 pm

NEW HAVEN
175 Sherman Avenue, 5th Floor, New Haven, CT 06511
Phone: (203) 789-3721 • **Fax**: (203) 867-5455
Hours: Monday – Friday 8 am – 5 pm

Yale-New Haven Hospital

If you are injured at work – first, notify your supervisor. Then choose from one of the four locations listed at the left to seek treatment. Workers' Compensation may not cover treatment if you seek care elsewhere. If possible, obtain a Yale-New Haven Hospital form from your supervisor and bring it with you to the treatment center along with your photo ID.

After hours, holidays, or if an ambulance is required, please use the Emergency Department at the closest Yale-New Haven facility:

Yale-New Haven Hospital
20 York Street, New Haven, CT

YNHH Saint Raphael Campus
300 Orchard Street, New Haven, CT

YNHH Shoreline Medical Center
111 Goose Lane, Guilford, CT

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...

TO GET YOUR WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM® sedgwick®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Sedgwick
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Call 1-800-964-2531 to establish First Fill benefit eligibility and to obtain the ID# for online adjudication of approved benefits for the injured individual.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		ENVOY
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-76_SEDGWCFFOP

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DECOMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionada:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM® sedgwick

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Sedgwick
PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL FECHA DE LA LESIÓN (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Call 1-800-964-2531 to establish First Fill benefit eligibility and to obtain the ID# for online adjudication of approved benefits for the injured worker.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		ENVOY
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-76_SEDGWCFFOP

YALE-NEW HAVEN HOSPITAL

YALE UNIV OCIP – The Graham Company **Date: _____**

CID = **Time: _____**

AUTHORIZATION FOR TREATMENT FORM

☐ **BRANFORD**
84 North Main Street, 2nd Fl.
Branford, CT 06405
Ph: (203) 789-5195
Fax: (203) 867-5223
Hours: M-F 8:30a -5p

☐ **EAST HAVEN**
317 Foxon Road
East Haven, CT 06513
Ph: (203) 466-5600
Fax: (203) 466-5630
Hours: M-F, 8a -7p; Sat 8a-3:30p; Sun, 9a-noon

☐ **HAMDEN**
2080 Whitney Avenue, Suite 150
Hamden, CT 06518
Ph: (203) 789-6240
Fax: (203) 789-6243
Hours: M-F, 8:30a-5p

☐ **NEW HAVEN**
175 Sherman Avenue, 5th Fl.
New Haven, CT 06511
Ph: (203) 789-3721
Fax: (203) 867-5455
Hours: M-F, 8a- 5p

PATIENT INFORMATION:

Patient Name: _____

Reason for Visit: _____

Employer: _____ Type of Work: _____

PERSON AUTHORIZING TREATMENT:

Name: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

I authorize Yale-New Haven Hospital to treat the employee named above and to perform the services indicated below**.**
By signing below, it is agreed that the above company will take full responsibility for payment of the services noted below unless other arrangements have been made in advance.

_____ _____ _____

Company Representative Name (print) *Company Representative Signature* *Date*

_____

Project Name

SERVICES REQUESTED

___ **Injury Care**

Physical Examination

___Pre-Placement / Post-Offer Exam
___ Fitness-for-Duty / Return-to-Work Exam
___ Respirator Clearance Exam
___ Asbestos Exam
___ Hazmat Exam
___ Periodic / Annual Exam
___ Other: _____

Drug Testing (Non-DOT)

___Preplacement ___For Cause

Other Services Upon Request

_____

_____

Screening Services

___Audiogram
___ Respirator Fit Test
___PPD Skin Test
___ Vaccine Type: _____
___ Titer Type:_____
___ OTHER:_____

Dept of Transportation / DOT Services ONLY

DOT Physical
___Pre-Placement ___Recertification

Drug Testing
___Pre-Employment ___Random ___For Cause
___Post-Accident ___Return-to-Duty

Breath Alcohol Test/BAT
___Pre-Employment ___Random ___For Cause
___Post Accident ___Return-to-Duty

AFTER HOURS CARE

Yale-New Haven Hospital
Emergency Department
20 York Street
New Haven, CT 06510

Yale-New Haven Hospital/ Saint Raphael Campus
Emergency Department
330 Orchard Street
New Haven, CT 06511

Yale-New Haven Shoreline Medical Center
111 Goose Lane
Guilford, CT 06437

GENERAL LIABILITY NOTICE OF OCCURRENCE/CLAIM

DATE (MM/DD/YYYY)

AGENCY / PHONE (A/C, No, Ext): 215-567-6300	X NOTICE OF OCCURRENCE / NOTICE OF CLAIM	DATE OF OCCURRENCE AND TIME	AM / PM	DATE OF CLAIM	PREVIOUSLY REPORTED	YES X	NO
The Graham Company The Graham Building One Penn Square West Philadelphia, PA 19102	EFFECTIVE DATE: 6/1/20	EXPIRATION DATE: 6/1/26	POLICY TYPE: X OCCURRENCE / CLAIMS MADE		RETROACTIVE DATE		
FAX (A/C, No):	COMPANY: XL Specialty Insurance (AXA XL)	NAIC CODE:	MISCELLANEOUS INFO (Site & location code)				
E-MAIL ADDRESS: CLICK HERE TO SUBMIT TO THE GRAHAM COMPANY							
CODE: / SUB CODE:	POLICY NUMBER: GDR 7457931		REFERENCE NUMBER				
AGENCY CUSTOMER ID: Kim Sharkey, CPCU, AIC, Vice President							

INSURED

NAME AND ADDRESS	SOC SEC # OR FEIN:	E-MAIL ADDRESS:	RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)
Yale University 149 Elm Street New Haven, CT 06511				

CONTACT

CONTACT INSURED

NAME AND ADDRESS	E-MAIL ADDRESS:	RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)	WHERE TO CONTACT	WHEN TO CONTACT
				Business	9:00 a.m. to 5:00 p.m.

OCCURRENCE

LOCATION OF OCCURRENCE (Include city & state)	AUTHORITY CONTACTED
DESCRIPTION OF OCCURRENCE (Use separate sheet, if necessary)	

POLICY INFORMATION

COVERAGE PART OR FORMS (Insert form #s and edition dates)

GENERAL AGGREGATE	PROD/COMP OP AGG	PERS & ADV INJ	EACH OCCURRENCE	FIRE DAMAGE	MEDICAL EXPENSE	DEDUCTIBLE	
$4,000,000	$4,000,000	$2,000,000	$2,000,000	$300,000	$10,000		PD / BI

UMBRELLA/ EXCESS	UMBRELLA	EXCESS	CARRIER:	LIMITS:	AGGR	PER CLAIM/OCC	SIR/ DED

TYPE OF LIABILITY

PREMISES: INSURED IS	OWNER	TENANT	OTHER:	TYPE OF PREMISES
OWNER'S NAME & ADDRESS (If not insured)				OWNERS PHONE (A/C, No, Ext):

PRODUCTS: INSURED IS	MANUFACTURER	VENDOR	OTHER:	TYPE OF PRODUCT
MANUFACTURER'S NAME & ADDRESS (If not insured)				MANUFACT PHONE (A/C, No, Ext):

WHERE CAN PRODUCT BE SEEN?

OTHER LIABILITY IN-CLUDING COMPLETED OPERATIONS (Explain)

INJURED/PROPERTY DAMAGED

NAME & ADDRESS (Injured/Owner)				PHONE (A/C, No, Ext)
AGE	SEX	OCCUPATION	EMPLOYER'S NAME & ADDRESS	PHONE (A/C, No, Ext)

DESCRIBE INJURY / ~~FATALITY~~	WHERE TAKEN	WHAT WAS INJURED DOING?

DESCRIBE PROPERTY (Type, model, etc)	ESTIMATE AMOUNT	WHERE CAN PROPERTY BE SEEN?	WHEN CAN PROPERTY BE SEEN?

WITNESSES

NAME & ADDRESS	BUSINESS PHONE (A/C, No, Ext)	RESIDENCE PHONE (A/C, No)

REMARKS

ALL RESERVATIONS OF RIGHTS/DENIAL LETTERS MUST BE SENT TO THE GRAHAM COMPANY FIRST. ALL FIRST PARTY DRAFTS MUST BE SENT DIRECTLY TO THE GRAHAM COMPANY.

REPORTED BY	REPORTED TO	SIGNATURE OF INSURED	SIGNATURE OF PRODUCER

Applicable in Arizona

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Applicable in Arkansas, Delaware, District of Columbia, Kentucky, Louisiana, Maine, Michigan, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, Virginia and West Virginia

Any person who knowingly and with intent to defraud any insurance company or another person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and [NY: substantial] civil penalties. In DC, LA, ME, TN and VA, insurance benefits may also be denied.

Applicable in California

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in Florida and Idaho

Any person who Knowingly and with the intent to injure, Defraud, or Deceive any Insurance Company Files a Statement of Claim Containing any False, Incomplete or Misleading information is Guilty of a Felony.*

* In Florida - Third Degree Felony

Applicable in Hawaii

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Applicable in Indiana

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Minnesota

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in Nevada

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

Applicable in New Hampshire

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Applicable in Ohio

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Oklahoma

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.