Turner Construction Company

Contractor Controlled Insurance Program (CCIP)
Great Wolf Lodge - Garden Grove
12681 Harbor Blvd., Garden Grove, CA 92840

CCIP Insurance Manual

This Manual is a Contract Document

This Manual Dated: 10/30/2013 (final))

TURNER CONTRACTOR CONTROLLED INSURANCE PROGRAM

Insurance Manual

Great Wolf Lodge - Garden Grove

PROJECT LOCATION:

12681 Harbor Blvd., Garden Grove, CA 92840

Southwest
1900 S. State College Blvd Suite #200 Anaheim CA 92806
Ph: 714-940-9000/Fx: 714-712-4415

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NOTE:

TSIB Form 1 through TSIB Form 4 can be completed On-Line. To obtain a User ID and Password, contact:
Turner Surety And Insurance Brokerage Wrap-up Service
Phone: (866) 684-WRAP
(866) 684-9727
(203) 283-2000
Email: WrapUp@tsibinc.com

section 1

Overview

Welcome to the Turner Contractor Controlled Insurance Program (CCIP).

You should notify your insurance agent(s) or broker(s) to endorse your coverage to be excess and contingent over the CCIP coverage provided under this Program for on-site activities and the related costs.

Each bidder is required to bid without the cost of their on-site Workers' Compensation, Employer's Liability, and General Liability primary and excess insurance. Turner may modify this bidding and insurance cost identification as necessary based on the specific project requirements. Bidder's completed and verified TSIB Form 2 along with its current Insurance Rate Sheets (see Section 6 "Identifying Subcontractor Insurance Costs") will be the basis for establishing what your corporate insurance costs would have been.

NOTE:
Insurance coverages and limits provided under the CCIP are limited in scope and are specific to work performed after the inception date of your enrollment into this program. **Your insurance representative should review this information.** Any additional coverage you may wish to purchase will be at your option and expense.

About This Manual

Turner Construction Company ("Turner") and Turner Surety And Insurance Brokerage ("TSIB") prepared this Insurance Manual. Turner is the Sponsor for this CCIP. TSIB is the CCIP Administrator for this CCIP. The Manual is designed to identify, define and assign responsibilities for the administration of the CCIP for this project. It also outlines the coverages provided by the CCIP, procedures for bidding, and the CCIP Enrollment process.

This Manual:

- Generally describes the structure of the CCIP
- Identifies responsibilities of the various parties involved in the Project
- Provides a basic description of CCIP coverage
- Describes audit and administrative procedures
- Provides answers to basic questions about the CCIP

This Manual does not:

- Provide coverage interpretations
- Provide complete information about coverages and exclusions
- Provide answers to specific claims questions

Refer questions concerning the CCIP, its administration or coverages to the appropriate party identified in the Project Directory, Section 2.

ADVISORY:
The information in this Manual is intended to outline the CCIP. If any conflict exists between this Manual and the CCIP insurance policies, the CCIP insurance policies will govern.

NOTE:
All payrolls submitted for this project should be excluded from the payrolls submitted to your corporate insurance carriers to avoid paying premiums for exposures covered by the Turner CCIP Program. The Workers' Compensation Policy issued to you and the Certificate of Insurance showing you as a Named Insured on the General Liability Policy may be used to provide evidence of your enrollment in the Turner CCIP to your corporate insurance carriers.

Section 2

CCIP Project Directory

CCIP Administration

SUBCONTRACTOR CONTACT –
Turner Surety And Insurance Brokerage Wrap-up Service

440 Wheelers Farms Road
Milford, CT 06461

Telephone: (866) 684-WRAP
(866) 684-9727
(203) 283-2000

Service Center Quality Assurance Specialist
David McClure

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Direct Phone: 203-283-2004

TURNER STAFF CONTACT –
Turner Surety And Insurance Brokerage

Regional Program Manager –
Christine Barton

Telephone: 503-552-0447
Cell: 201-574-6433
E-mail: cbarton@tsibinc.com

Liberty Mutual Insurance Company

Regional Loss Control Manager –
Robert Pinney

Telephone: 800-821-0967 ext. 2208
Cell: 916-981-8090
E-mail: robert.pinney@libertymutual.com

Turner Construction Company – Project Team

Project Manager – Paul Costa	Telephone: 213-216-4389 Cell: 213-216-4389 E-mail: pcosta@tcco.com
Site Safety Manager – Dave McGee	Telephone: 213-216-5005 Cell: 213-216-5005 E-mail: davmcgee@tcco.com
Project Superintendent - Mark Rivera	Telephone: 713-840-8441 Cell: 832-470-0543 E-mail: mrivera@tcco.com
Project Engineer - Richard Salguero	Telephone: 714-940-9075 Cell: 213-216-3169 E-mail: rsalguero@tcco.com
Claim Coordinator - Laurence Singerman	Telephone: 714-940-9031 Cell: 213-216-5769 E-mail: lsingerman@tcco.com
CCIP Coordinator– Laurence Singerman	Telephone: 714-940-9031 Cell: 213-216-5769 E-mail: lsingerman@tcco.com

Section 3

Project Definitions

The following list includes key CCIP definitions.

CCIP:	A "CCIP" or Contractor Controlled Insurance Program is a coordinated insurance program providing certain coverages, as defined herein, for Turner and eligible Enrolled Parties performing Work at the Project Site.
CCIP SPONSOR:	Turner Construction Company ("Turner" or "Turner Construction")
CCIP ADMINISTRATOR:	Turner Surety And Insurance Brokerage ("TSIB")
CCIP INSURER:	The insurance company(ies) named on a policy or certificate of insurance providing coverage for the CCIP.
SUBCONTRACT / SUBCONTRACT AGREEMENT:	A written agreement between the Sponsor and the Subcontractor.
SUB-SUBCONTRACT / SUB-SUBCONTRACT AGREEMENT:	A written agreement between the Subcontractor and a Sub-subcontractor(s) of any tier.
SUBCONTRACTOR:	Includes only those persons, firms, joint venture entities, corporations, or other parties that enter into a contractual agreement with Turner to perform Work at the Project Site
SUB-SUBCONTRACTOR:	Includes only those persons, firms, joint venture entities, corporations, or other parties that enter into a contractual agreement with a Subcontractor to perform Work at the Project Site
CERTIFICATE OF INSURANCE:	A document providing evidence of existing coverage for a particular insurance policy or policies.
WELCOME LETTER:	A document issued by the CCIP Administrator, which confirms acceptance/ enrollment of the applicant into the CCIP.
PROJECT SITE:	Generally defined as the "project location" (designated in this Manual and more fully identified in the Subcontract Agreement) and adjacent or nearby areas as defined in the project documents where incidental operations are performed excluding permanent locations of any insured party.

ELIGIBLE PARTIES/ELIGIBLE SUBCONTRACTOR (SUB-SUBCONTRACTOR)	Parties performing labor or services at the Project Site who are eligible to enroll in the CCIP unless an Excluded Party.
ENROLLED PARTIES/ENROLLED SUBCONTRACTOR (SUB-SUBCONTRACTOR):	Those eligible Subcontractors who have submitted all necessary enrollment information as detailed in Section 6 and have been accepted into the CCIP as evidenced by a Welcome Letter and Certificate of Insurance.
PARTY NO LONGER COVERED BY THE CCIP:	A Party whose CCIP insurance coverage has been terminated. Upon termination of CCIP coverages, the Party is to provide insurance coverage for both on and off the Project Site activities as listed in this Manual (see Section 5, Subcontractor Maintained Coverages) and in the limits as stated in the Subcontract Agreement Form.
EXCLUDED PARTIES/EXCLUDED SUBCONTRACTORS:	At the discretion of Turner, or subject to State regulations, the following parties will be excluded from enrollment in the CCIP: (1) Hazardous materials remediation, removal and/or transport companies and their consultants; (2) Any Subcontractor performing Structural Demolition (Structural Demolition is the moving or relocating of load bearing beams, columns, or walls); (3) Architects, engineers, soil testing engineers, surveyors, and their consultants; (4) Vendors, suppliers, fabricators, material dealers, truckers, haulers, drivers and others who merely transport, pickup, deliver, or carry materials, personnel, parts or equipment or any other items or persons to or from the Project Site; (5) Subcontractors, and any of their respective Sub-subcontractors, who do not perform any actual labor on the Project Site; (6) Turner's first tier Subcontractors with aggregate Subcontract value of less than $25,000; (7) Third Party Scaffolding Subcontractors of any tier; (8) Third Party Crane Subcontractors / Companies of any tier as well as Subcontractors of any tier engaged in the erecting, dismantling or "jumping" of cranes; (9) Building implosion Subcontractors including Subcontractors of any tier involved with blasting or the use of explosives; (10) Window Washing Systems (davit type systems or equivalent). (11) Turner may include an Excluded Party, or exclude an Eligible Party, at its sole discretion.
SUBCONTRACTOR AND SUB-SUBCONTRACTOR INSURANCE COSTS:	Subcontractor's and its Sub-subcontractors of all tiers corporate insurance costs that would be required if the CCIP insurance coverage was not provided.
VERIFIED INSURANCE COST:	The Subcontractor and Sub-subcontractor corporate insurance cost that has been verified as accurate by the CCIP Administrator.

VERIFIED BLENDED PAYROLL RATE:	Rate determined by dividing the Subcontractor's (Sub-subcontractor's) total Verified Insurance Cost by the Subcontractor's (Sub-subcontractor's) estimated payroll, then times 100. The Rate is expressed as per $100 of payroll. (Verified Blended Payroll Rate = (Verified Insurance Costs / Estimated Payroll) * 100)
CONTRACTOR INSURANCE COST LETTER	Letter written by the CCIP Administrator confirming the Verified Insurance Costs and Verified Blended Payroll Rate.
WORK:	Operations, as fully described in the Subcontract Agreement, performed at the Project Site.

Section 4

CCIP Insurance Coverage

This Section provides a brief description of the CCIP Coverage. Subcontractor should refer to the actual CCIP insurance policies for details concerning coverage, exclusions and limitations.

Overview

As the CCIP sponsor, Turner has arranged with Turner Surety And Insurance Brokerage (the "CCIP Administrator") for designated projects, including this Project, to be insured under its Turner Contractor Controlled Insurance Program ("CCIP"). The CCIP is more fully described in this Manual. Parties performing labor or services at the Project Site are eligible to enroll in the CCIP unless that party is an Excluded Party or a Party No Longer Covered by the CCIP. The CCIP will provide to Enrolled Parties Workers' Compensation and Employer's Liability Insurance, Commercial General Liability Insurance, and Excess Liability Insurance, as summarily described below, in connection with the performance of the Work ("CCIP Coverages").

Excluded Parties and Parties No Longer Covered by the CCIP

Excluded Parties are not granted any insurance coverage under the CCIP. ***Excluded Parties*** and ***Parties No Longer Covered by the CCIP*** must meet the insurance requirements established in Section 5 and in the Subcontract Agreement Form, and provide evidence of coverage to Turner. ***Excluded Parties*** and ***Parties No Longer Covered by the CCIP*** are defined in Section 3, "Project Definitions".

Excluded Parties and ***Parties No Longer Covered by the CCIP*** shall require each of its Sub-subcontractors to obtain and maintain the insurance coverage specified elsewhere in this Manual and in the Subcontract Agreement Form.

Evidence of Coverage

CCIP Coverages shall cover only Enrolled Parties. Enrolled Parties are: Turner, eligible Subcontractors, and eligible Sub-subcontractors who enroll in the CCIP, and such other persons or entities as Turner at its sole discretion may designate.

Each Enrolled Party will be issued an individual workers' compensation policy provided by Liberty Mutual, the CCIP primary insurer. The CCIP Administrator will provide a Certificate of Insurance evidencing workers' compensation, general liability, and excess liability to each Enrolled Party, each of who will be added as an Additional Named Insured to the CCIP General Liability insurance policy. Liberty Mutual will furnish other documents including claim forms, posting notices, etc., to each Enrolled Party. A copy of the primary General Liability policy can be obtained upon Subcontractor's written request to Turner. Copies of Excess/Umbrella policies are not available, nor are they available for review.

Description of CCIP Coverages

The CCIP coverages and exclusions summarized in this Manual and the other Contract Documents are set forth in full in their respective insurance policy forms. The summary descriptions of the CCIP coverages in this Manual are not intended to be complete or to alter or amend any provision of the actual CCIP coverages. In the event any provision of this Manual, the Contract Documents, or the summary below conflicts with the CCIP insurance policies, the provisions of the actual CCIP insurance policies shall govern.

CCIP coverages shall apply only to those operations of each Enrolled Party performed at the Project Site in connection with the Work and only to Enrolled Parties that are eligible for the CCIP, even if erroneously enrolled in the CCIP.

Turner will furnish the following coverages to all Enrolled Parties performing Work at the Project Site.

Summary Only

A separate workers' compensation policy will be issued to each enrolled Party.

Workers' Compensation and Employer's Liability

Coverage: Statutory limits required by the Workers' Compensation laws of the applicable jurisdiction, excluding monopolistic states, with Employer's Liability.

Part One -	Workers' Compensation	Statutory Limit
Part Two -	Employer's Liability	**Annual Limits Per Enrolled Party**
	Bodily Injury by Accident, each accident	$2,000,000
	Bodily Injury by Disease, each employee	$2,000,000
	Bodily Injury by Disease, policy limit	$2,000,000

- This policy does not cover off-site operations of any Enrolled Party.
- **This insurance is primary for all occurrences at the Project Site.**

A single general liability policy will be issued for all Enrolled Parties with all Enrolled Parties Named as Insureds.

Commercial General Liability

Coverage: Third Party Bodily Injury and Property Damage Liability.

	Limits of Liability Shared by All Enrolled Parties
General Aggregate Per Project	$4,000,000
Products/Completed Operations Aggregate Per Project	$4,000,000
Each Occurrence Limit	$2,000,000
Fire Damage Legal Liability (any one fire)	$100,000
Medical Expense Limit (any one person)	$5,000

General Liability Insurance generally equivalent to ISO Occurrence Form 2007 or later.

- This insurance is primary for all covered occurrences at the Project Site.
- This insurance will NOT provide coverage to any insured party, vendor, supplier, off-site fabricator, material dealer or other party for any product manufactured, assembled or otherwise worked upon away from the Project Site.
- This policy does not cover off-site operations of any Enrolled Party.
- Products & Completed Operations Extension of the Project with a single non-reinstated aggregate limit for the period beginning from the earliest occurrence of (i) when the Project is put to its intended use, (ii) project completion, or (iii) CCIP policy termination, and ending after the earlier occurrence of (i) ten (10) years or (ii) the expiration of the applicable statute of repose established per the civil code of the state where the Project is located.
- **The policy contains exclusions.** Some of these exclusions are: Real & Personal Property in the care, custody or control of the insured; Asbestos; Discrimination & Wrongful Termination; Architects & Engineers Errors & Omissions; Owned & Non-owned Aircraft, Watercraft, and Automobile Liability; Nuclear Broad Form Liability, Pollution except hostile fire.

Excess Liability – A minimum of:

Limits of Liability

Single excess liability policies will be issued for all Enrolled Parties.

	Shared by All Enrolled Parties
Each Occurrence Limit (Combined Single Limit)	$50,000,000
Products/Completed Operations Aggregate Per Project	$50,000,000
Annual General Aggregate Limit Per Project	$50,000,000

- Policy follows form (provisions, coverages, exclusions, etc.) of underlying Commercial General Liability and Employer's Liability policy wording.

GENERAL LIABILITY OBLIGATION

At Turner's discretion, the Subcontractor may be required to pay up to the first **$5,000** per occurrence to the extent losses payable are attributable to Subcontractor's Work, or the acts or omissions of its Sub-subcontractors, or any other party performing any of the Work for whom the Subcontractor may be contractually or legally responsible. All monies collected via this obligation will be reinvested into site safety/performance awards

Property of Subcontractors

Note:

Subcontractors are advised to arrange their own insurance for rented, owned, leased or borrowed equipment and materials not intended for inclusion in the Project. The CCIP will not cover Subcontractor property.

Section 5

Subcontractor Maintained Coverage

Subcontractors and all Sub-subcontractors are required to maintain coverage to protect against losses that occur away from the Project Site or that are otherwise not covered under the CCIP. All Certificates of Insurance must be submitted to the CCIP Administrator prior to mobilization.

Subcontractors and their Sub-subcontractors are required to maintain insurance coverage for the duration of the Subcontract that protects Subcontractor, Turner, the Project Owner, and others as required from liabilities. These liabilities may arise from the Subcontractor's operations performed away from the Project Site, from coverages not provided by the CCIP, or from operations performed by Excluded Parties or Parties No Longer Covered by the CCIP. The CCIP places Subcontractors into one of two main categories: Enrolled Parties or Excluded Parties.

See Section 8 for sample Offsite Certificate of Insurance.

- **Enrolled Parties** are to provide evidence of Workers' Compensation, General Liability and Excess/Umbrella Liability insurance for off-site activities, Automobile Liability (both on-site and off-site activity), and any other insurance as per the insurance specifications in the Subcontract Agreement. See Section 3 for the definition of Enrolled Parties.
- **Excluded Parties** and **Parties No Longer Covered by the CCIP** must provide evidence of Workers' Compensation, General Liability, Excess/Umbrella Liability, Automobile Liability, and any other insurance as per the insurance specifications in the Subcontract Agreement for all activities both on and off the Project Site.

Certificate of Insurance

- Prior to mobilization and within three (3) days of renewal, change or replacement of coverage, Subcontractors will submit to the CCIP Administrator a Certificate of Insurance evidencing the coverage and limits as specified in this section.
- A waiver of subrogation and additional insured (CG 20 10 11 85 or its equivalent) status is required on all Certificates.
- The Certificate of Insurance must name The Turner Corporation, Turner Construction and others as reasonably requested as an additional insured on a primary, non-contributory basis, to all Liability policies.

Verification of Required Coverages

Subcontractors shall provide verification of insurance to the CCIP Administrator prior to mobilization and within three (3) days of any renewal, change or replacement of coverage. A sample of an acceptable Certificate of Insurance is provided in Section 8. **Please note the requirements for waiver of subrogation, primary and non-contributory language and additional insured status.**

Subcontractors are responsible for collecting, monitoring and retaining copies of their Sub-subcontractor's Certificates of Insurance. Turner, at its sole discretion, may request copies of lower tier Certificates of Insurance to ensure compliance with the requirements of this Manual. Turner reserves the right to disapprove the use of Subcontractors or Sub-subcontractors unable to meet the insurance requirements or who do not meet other Turner policy requirements.

The limits of liability shown for the insurance required of the Subcontractors and Sub-subcontractors are minimum limits only and are not intended to restrict the liability imposed on the Subcontractors for work performed under their Subcontract.

Subcontractor Maintained Coverages

Additional Insurance Required From Enrolled Parties, Excluded Parties, and Parties No Longer Covered by the CCDIP

Subcontractor and their Sub-subcontractors shall obtain and maintain, and shall require each of its Sub-

subcontractors to obtain and maintain, the insurance coverage specified in this Section in a form and from insurance companies reasonably acceptable to Turner. The insurance limits may be provided through a combination of primary and excess policies, including the umbrella form of policy. Each policy required under this Section, except for Workers' Compensation and Professional Liability, shall name The Turner Corporation, Turner Construction Company, Owner, other additional insured parties, their respective officers, agents and employees, and any additional entities as Turner may request as additional insureds. Coverage is to be afforded on a primary and non-contributory basis with respect to any other insurance available to the additional insured. The additional insured endorsement utilized for the General Liability policy must provide coverage as broad as that available under the ISO CG 20 10 11 85 or its equivalent endorsement.

In the event that the law of the state in which the project is located (or other applicable law) limits the indemnity obligations of the subcontractor, then the indemnity obligations of the subcontractor shall be enforced to the fullest extent permitted by applicable law, and this Manual shall be construed to conform to such law.

Waiver of Subrogation. Where permitted by law, Subcontractor hereby waives all rights of recovery by subrogation because of deductible clauses, inadequacy of limits of any insurance policy, limitations or exclusions of coverage, or any other reason against Turner, Owner, the other additional insured parties, the CCIP Administrator, their respective officers, agents, or employees, and any other contractor, Subcontractor, or Sub-subcontractor performing Work or rendering services on behalf of Turner in connection with the planning, development and construction of the Project. Where permitted by law, Subcontractor shall also require that all Subcontractor's maintained insurance coverage related to the Work include clauses providing that each insurer shall waive all of its rights of recovery by subrogation against Subcontractor together with the same parties referenced immediately above in this Section. Subcontractor shall require similar written express waivers and insurance clauses from each of its Sub-subcontractors. A waiver of subrogation shall be effective as to any individual or entity even if such individual or entity (a) would otherwise have a duty of indemnification, contractual or otherwise, (b) did not pay the insurance premium directly or indirectly, and (c) whether or not such individual or entity has an insurable interest in the property damaged.

As to Eligible and Enrolled Parties, the Workers' Compensation, Employer's Liability, and Commercial General Liability insurance required by this Section shall only be for off-site activities or operations not insured under the CCIP Coverages. The following insurance coverages are to be provided by an insurance carrier selected by the Subcontractor and Sub-subcontractors. All costs for insurance coverages for off-site activities or operations are included in the Price and are paid by Subcontractor.

(1) Standard Commercial Automobile Liability Insurance covering all owned, non-owned and hired automobiles, trucks, and trailers with a combined single limit of not less than $1,000,000 (except for operations in the State of New York where the single limit shall not be less than $2,000,000).

(2) Statutory Workers' Compensation Insurance and Employer's Liability insurance, including Maritime coverage, if appropriate, and Employer's Liability limits shall be provided of not less than $1,000,000 each accident/$1,000,000 each employee/$1,000,000 policy limit for **enrolled** subcontractors and not less than $2,000,000 each accident/$2,000,000 each employee/$2,000,000 policy limit for **excluded** subcontractors.

(3) Commercial General Liability Insurance in a form providing coverage not less than the standard ISO Commercial General Liability insurance policy ("Occurrence Form"), including Completed Operations, Contractual Liability Insurance against the Liability assumed herein, and including Independent Contractors Liability Insurance if the Subcontractor sublets to another all or any portion of the Work, Personal Injury Liability, Broad Form Property Damage (including completed operations, and Explosion, Collapse and Underground Hazards, with the following minimum limits: (coverage shall be equivalent to ISO Occurrence Form 2007 or later) The minimum insurance limits are set forth in the "Invitation to Bid", the Subcontract Agreement, or as otherwise instructed by Turner. If no indication is given, then the minimum required limits will be $5,000,000 ($10,000,000 in

New York State).

(4) If required by Turner, Aviation and/or Watercraft Liability Insurance, in form and with limits of liability and from an insuring entity reasonably satisfactory to Turner.

(5) If required by Turner, Contractor's Pollution Liability Insurance in form and with limits of liability and from an insuring entity reasonably satisfactory to the Turner.

If the Subcontractor fails to procure and maintain the additional Insurance required from Enrolled Parties, Excluded Parties, and Parties No Longer Covered by the CCIP, Turner shall have the right, but not the obligation, to procure and maintain said insurance for and in the name of the Subcontractor and/or Sub-subcontractor and the Subcontractor and/or Sub-subcontractor shall pay the cost thereof and shall furnish all necessary information to make effective and maintain such insurance. At Turner's option, Turner may offset the cost incurred by Turner against amounts otherwise payable to Subcontractor hereunder.

Enrolled Parties will provide evidence of workers' compensation insurance for all activities away from the Project Site.

Excluded Parties and Parties No Longer Covered by the CCIP will provide evidence of workers' compensation insurance for all activities at and away from the Project Site.

Workers' Compensation and Employer's Liability – Enrolled Contractors

Part One -	Workers' Compensation	Statutory Limit
Part Two -	Employer's Liability	**Annual Limits**
	Bodily Injury by Accident, each accident	$1,000,000
	Bodily Injury by Disease, each employee	$1,000,000
	Bodily Injury by Disease, policy limit	$1,000,000

Coverage will apply away from the Project Site for Enrolled Parties.

Workers' Compensation and Employer's Liability – Excluded Contractors

Part One -	Workers' Compensation	Statutory Limit
Part Two -	Employer's Liability	**Annual Limits**
	Bodily Injury by Accident, each accident	$2,000,000
	Bodily Injury by Disease, each employee	$2,000,000
	Bodily Injury by Disease, policy limit	$2,000,000

- Coverage will apply on and off-site for Excluded Parties and Parties No Longer Covered by the CCIP.

Commercial General Liability/Umbrella Liability

Enrolled Parties shall provide evidence of general liability insurance for off-site activities with Turner and other required parties named as additional insureds (CG 20 10 11 85 version or its equivalent) to the policy.

Excluded Parties and parties No Longer Covered by the CCIP shall provide evidence of general liability insurance applicable to these Projects and must name Turner and other required parties as additional insureds (CG 20 10 11 85 version or its equivalent) to their policy.

Commercial General Liability Insurance Including Completed Operations, Contractual Liability Insurance against the Liability assumed herein, and including Independent Contractors Liability Insurance if the Subcontractor sublets to another all or any portion of the Work, Personal Injury Liability, Broad Form Property Damage (including completed operations), and Explosion, Collapse and Underground Hazards, with the following minimum limits: (coverage shall be equivalent to ISO Occurrence Form 2007 or later)

	Limits of Liability
Combined Single Limit	**As stipulated in Article XXIII of the Subcontract Agreement, in the Invitation to Bid, or as otherwise instructed by Turner. If no indication is given, then the minimum required limits are $5,000,000 ($10,000,000 in New York State).**

Coverage will apply away from the Project Site for Enrolled Parties. Coverage will apply on-site and off-site for Excluded Parties and Parties No Longer Covered by the CCIP.

Automobile Liability

ALL contractors shall provide evidence of automobile liability insurance with Turner and other required parties named as additional insureds to the policy. **The CCIP does not cover automobile liability.**

Commercial Automobile Liability insurance covering all owned, hired and non-owned automobiles, trucks and trailers used in connection with the work with the following minimum limits:

	Limits of Liability
Combined Single Limit – Each Accident Bodily Injury And Property Damage	**As stipulated in Article XXIII of the Subcontract Agreement, in the Invitation to Bid, or as otherwise instructed by Turner. If no indication is given, then the minimum required limit is $1,000,000 ($2,000,000 in New York State).**

For Enrolled Parties, Excluded Parties, and Parties No Longer Covered by the CCIP, coverage will apply both on and off the Project Site.

Property Insurance

The CCIP **does not** provide coverage for Subcontractors personal property.

Subcontractors must provide their own insurance for owned, leased, rented and borrowed equipment, whether such equipment is located at a Project Site or "in transit". Subcontractors are solely responsible for any loss or damage to their personal property including, without limitation, property or materials created or provided under the Subcontract until installed at the Project Site, Subcontractor tools and equipment, scaffolding and temporary structures.

Watercraft and Aircraft Liability

The CCIP **does not** provide Watercraft or Aircraft Liability insurance.

The operator of any watercraft or aircraft of any kind must maintain liability insurance naming Turner, the Owner, and others as required, and the respective Subcontractor as an additional insured with primary and non-contributory wording. In addition, the limit of liability must be satisfactory to Turner. Such project-specific insurance requirements will be indicated in the Subcontract Agreement.

Professional Liability

The CCIP **does not** provide Professional Liability insurance.

All professional service firms must provide professional liability insurance appropriate for their profession. Architect and engineering firms must provide insurance covering liability arising out of design errors and omissions with a limit of not less than $1,000,000 per claim for prime design contractors (refer to Turner Subcontract Agreement Form for additional requirements and higher limits if required).

Pollution Liability

The CCIP **does not** provide Pollution Liability insurance.

A Subcontractor whose Work involves removal or treatment of hazardous materials will provide and maintain Contractors Pollution Liability insurance. Such coverage will specifically schedule the type of work defined in the Subcontract. Such project-specific insurance requirements will be indicated in the Subcontract Agreement Form.

Completed Operations Coverage

Each Enrolled Party will provide Completed Operations coverage from termination of the CCIP provided Completed Operations coverage (as shown on page 12) through the Statue of Repose applicable for the State in which the Project is located. **All Enrolling Parties are strongly advised to provide a copy of this Manual and this provision to their insurance professional so the proper coverage extension is arranged.**

Section 6

Subcontractor Responsibilities and Obligations

Throughout the course of the Project, Subcontractors of any tier will be responsible for reporting and maintaining certain records as outlined in this Section.

The Subcontractor and its Sub-subcontractors are required to cooperate with Turner, the insurance carrier(s), and the CCIP Administrator in all aspects of CCIP operation and administration. The responsibilities and obligations of the Subcontractors and Sub-subcontractors include, but are not limited to, those as stated or outlined below.

Notice to all Out-Of-State Subcontractors
All Out-of-State Subcontractors of any tier are advised to contact the workers' compensation department in the state where the project is located regarding requirements and compliance with the local Workers' Compensation Laws and Regulations.

Subcontractor Bids

See Section 8 for sample forms that can help identify your insurance costs.

See Section 2 for information on contacting the CCIP Administrator.

Under the CCIP, Turner provides insurance for all Enrolled Parties for Work performed at the Project Site. The section below, "Identifying Subcontractor Insurance Costs," describes the procedures for bidding, and how CCIP insurance amounts are paid. Section 8 of this Manual contains several worksheets that can help you determine your Subcontractor Insurance Costs for this Project. The CCIP Administrator can also help with this calculation.

Identifying Subcontractor Insurance Costs

Until each Subcontractor submits all required documentation to calculate the subcontractor insurance cost, a subcontractor insurance cost equal to 3% of the subcontract value shall be utilized.

Each Subcontractor is required to exclude from its bid its cost for the insurance coverages that are provided under the CCIP program. Turner may modify this bidding and insurance cost identification as necessary by the specific project requirements.

In addition, the Subcontractor is required to submit with its bid, a completed **Insurance Cost Worksheet** form (TSIB Form 2) unless instructed otherwise by Turner's Purchasing Agent. A separate Form 2 is required for the Subcontractor's self-performed work and each identified Sub-subcontractor.

Detailed Insurance Costs for each Subcontractor's own insurance program, the estimated unburdened payroll (payroll without taxes, fringes, benefits and overtime) for that portion of the Work that will be performed at the Project Site ("Initial Payroll Estimate"), and projected subcontract amount are captured on the TSIB Form 2 form. This information, along with the insurance documentation outlined below, is used by the CCIP Administrator to verify the adequacy of the submitted Subcontractor Insurance Costs and establish the Verified Blended Payroll Rate.

Each Subcontractor is required to submit insurance documentation that supports the information supplied on the TSIB Form 2. Documentation includes copies of the following pages from Workers' Compensation, General Liability and Excess Liability policies as follows:

- Declaration or Information Page
- Rate Page(s)
- Experience Modification Verification (Workers' Compensation only)

If the Subcontractor is "self insured", carries a deductible or declares a dividend credit for its Workers' Compensation and/or General Liability program, then the following must also be provided:

- Deductible Page(s)
- 5 Years of loss history for entities that retain losses (summary level)
- 5 Years of audited payroll by annual total

Note: Deductible and/or Dividend Credits
If Subcontractor (Sub-subcontractor) fails to submit the required Deductible Page(s), loss history and historical audited payroll information (summary level), the CCIP Administrator will make one (1) written request (email) for this information. If the necessary information is not received by the CCIP Administrator within seven (7) days of the written request, Subcontractor's (Sub-subcontractor's) Verified Insurance Cost and Verified Blended Payroll Rate (see below) will be calculated eliminating the deductible and/or dividend credit. Verified Insurance Cost and Verified Blended Payroll Rate may not be recalculated should Subcontractor (Sub-subcontractor) submit the required information at a later date.

In those instances where the TSIB Form 2 is not completed correctly, or are not specific to the scope of work, or the scope of work has changed, the Subcontractor may be asked to re-complete the form for their work or their sub-subcontracted work. Turner or the CCIP Administrator may also perform a recalculation based upon revised estimated payrolls or copies of rating information. A new Form 2 may be required if the estimated payroll on the Form 1 (Application for Enrollment Form) is different that the payroll on the Form 2. The Estimated Payroll on the Form 2 is the estimate that will now be used in the final adjustment calculation. Until each Subcontractor or Sub-subcontractor submits all required documentation to calculate the subcontractor insurance cost, a subcontractor insurance cost equal to 3% of the contract value may be utilized by Turner.

Note: Form 2 "Insurance Cost Worksheet" Calculations
When completing the Form 2, apply all discounts, modifiers, etc. as shown on the policy's Insurance Rate Pages or Declaration Page. If you are unable to do so, follow the "Instruction" Page of the Form 2 for the order of applying the discounts and modifiers. Upon review of the completed Form 2, the CCIP Administrator will apply discounts and modifiers in the order as indicated on the Insurance Rate Pages or Declaration Page. Upon completion of the review, the CCIP Administrator will issue to the Enrolling Subcontractor (Sub-subcontractor) the Contractor Insurance Cost Letter indicating the Verified Blended Payroll Rate and Verified Insurance Cost Amount.

Adjustments for Subcontractor Insurance Costs

The Subcontractor's (Sub-subcontractor's) Verified Blended Payroll Rate for each Enrolling Party is computed on the **Insurance Cost Worksheet** form (TSIB Form 2). Prior to the Subcontract being awarded, unless modified by Turner, the CCIP Administrator will determine the Verified Blended Payroll Rate. The Verified Blended Payroll Rate, along with the Verified Insurance Cost, will be acknowledged to the Enrolling Party and Turner in writing via a Contractor Insurance Cost Letter. Where allowable by law or state regulations, Turner may use the Verified Blended Payroll Rate to calculate the final adjustments (based upon actual reported monthly payroll or Insurance Carrier audit results) in payments to the Subcontractor for work performed under the CCIP. The formula for this calculation is provided below.

The Verified Blended Payroll Rate is determined by dividing the Subcontractor's (Sub-subcontractor's)

Total Verified Insurance Costs by the Subcontractor's (Sub-subcontractor's) Estimated On-Site Payroll as detailed on the TSIB Form 2. The Verified Blended Payroll Rate is expressed as per $100 of on-site labor payroll. (Verified Blended Payroll Rate = (Verified Insurance Costs / Estimated On-Site Payroll) * 100). Once established, it is set for the life of the Subcontractor's (Sub-subcontractor's) performance of Work on site.

Upon completion of the Work, Turner, at its sole discretion, may direct the CCIP Administrator to calculate the Subcontractor's Additional Insurance Cost, and may deduct such costs from future payments, based on the following formula:

	Total Reported/Audited Payroll (including all Change Order work)
Minus	Initial Payroll Estimate / Estimated On-Site Payroll from Form 2
Minus	Change Order Payroll Estimate
Equals	Additional Subcontract Payroll
Times	Verified Blended Payroll Rate (per $100 of payroll)
Equals	Subcontractor's (Sub-subcontractor's) Additional Insurance Cost

Example:		
Total Reported Payroll (including all Change Orders)	=	$1,000,000
Minus Initial Payroll Estimate	=	$ 700,000
Minus Payroll Estimate from Change Orders	=	$ 100,000
Equals Additional Payroll	=	$ 200,000
Times Verified Blended Payroll Rate (per $100 of payroll)	=	$ 10.00
Equals Subcontract Additional Insurance Cost	=	$ 20,000

At Turner's sole discretion, a final additional insurance cost for the SUBCONTRACT may be calculated as follows:

	Subcontractor's Additional Insurance Cost
Plus	**Sum of all Sub-subcontractor's Additional Insurance Costs**
Equals	**Subcontractor's Final Additional Insurance Cost**

Turner, at its option, may choose to perform an interim insurance cost adjustment should the Subcontractor's man-hours or payroll exceed the estimated man-hours or payroll for the Subcontract. Subcontractor is solely responsible for recovering additional insurance costs from its Sub-subcontractors.

Insurance Carrier Payments

Turner will, on behalf of the Subcontractor and its enrolled Sub-subcontractors, make payment to the relevant Workers' Compensation and General Liability companies for the on-site provided coverage.

Withhold of Payments

In the event of a Turner audit of Subcontractor's records and information as permitted in the Subcontract Agreement, this Manual, or other Contract Documents reveals a discrepancy in the insurance, payroll, safety, or any other information required by the Contract Documents to be provided by Subcontractor to Turner, or to the CCIP Administrator, or reveals the inclusion of "Insurance Cost" amount in any payment for the Work, Turner shall have the right to withhold or deduct from the Price all such "Insurance Cost" amounts. If the Subcontractor or its Sub-subcontractor fail to timely comply with the provisions of this Manual, Turner may withhold any payments due Subcontractor and its Sub-subcontractors until such time as they have performed the requirements of this Manual.

Note:
Failure to submit any CCIP insurance forms as required may result in the withholding of payments by Turner until required documentation is received.

Enrollment

See Section 8 for sample of CCIP forms

Each Subcontractor and Sub-subcontractor shall provide details about its Sub-subcontractors as necessary for CCIP enrollment. All of the information requested on the **Application for Enrollment** form (TSIB Form 1 in Section 8) is required for enrollment. This form must be completed and submitted to the CCIP Administrator prior to mobilization to obtain coverage under the CCIP.

A separate **Application for Enrollment** form (TSIB Form 1) is required for each eligible Sub-subcontractor of any tier that performs Work at the Project Site.

The CCIP Administrator will issue to each Enrolled Party a Welcome Letter and a CCIP Certificate of Insurance acknowledging acceptance of the applicant into the CCIP. The insurance carrier will issue a separate Workers' Compensation policy to each Enrolled Party.

Note: Enrollment is not automatic!
Enrollment into the CCIP is required, but not automatic. Access to the Project Site will not be permitted until enrollment is complete. Eligible Subcontractors and Sub-subcontractors MUST complete the enrollment forms and submit to the CCIP Administrator who will confirm complete enrollment into the CCIP. If a Subcontractor or Sub-subcontractor obtains access to the site, with or without Turner's knowledge, CCIP coverage will not be provided if Subcontractor or Sub-subcontractor is not enrolled. Unenrolled/Excluded Parties/Parties No Longer Covered by the CCIP do not have any insurance coverage under the CCIP.

Note: Late Enrollments / Late Reporting – Carrier Fines
Should the insurance carrier(s) assess fines or penalties for late enrollment and/or late reporting, Turner reserves the right to assess these fines to the prime tier (first tier) Subcontractor. This reservation of rights applies whether fines and/or penalties are due to the prime tier Subcontractor or any of its Sub-subcontractors. If a fine or penalty is assessed to a Sub-subcontractor, the prime tier Subcontractor is solely responsible for recovering fine or penalty amount from its Sub-subcontractors.

Assignment of Premiums

Turner pays the cost of the CCIP insurance coverage. All Enrolled Parties will assign to Turner all adjustments, refunds, premium discounts, dividends, costs or any other monies due from the CCIP insurer(s). Subcontractors will ensure that its Sub-subcontractor(s) has executed such an assignment. The **Application for Enrollment** form (TSIB Form 1 in Section 8) will be used for this purpose.

Payroll Reports

See Section 8 for On-Site Payroll Report forms.

NOTE:
All payrolls submitted for this project should be excluded from the payrolls submitted to your corporate insurance carriers to avoid paying premiums for exposures covered by the Turner CCIP Program. The Workers' Compensation Policy issued to you and the Certificate of Insurance showing you as a Named Insured on the General Liability Policy may be used to provide evidence of your enrollment in the Turner CCIP to your corporate insurance carriers.

By the 10th of each month every Enrolled Party must submit to the CCIP Administrator an **On-Site Payroll Report Information** (TSIB Form 3) identifying man-hours and payroll for all work performed at the Project Site. This report shall classify the labor expended at each Project Site according to the Standard Workers' Compensation Insurance Classification and included in the Subcontractor's Application for Enrollment Form (TSIB Form 1).

NOTE: The monthly On-Site Payroll Report Information should include the unburdened "straight-time" payroll and the unburdened "straight-time" portion of any "overtime" payroll (except in the states of Pennsylvania, Nevada, Utah, Delaware and applicable Workers' Compensation monopolistic States which require the entire unburdened "overtime" payroll to be reported) for all CCIP qualified employees, including on-site supervisors and on-site clerical personnel.

A monthly payroll report must be submitted for each month, including "zero dollar ($0.00) payroll" if applicable, until completion of the work under each Subcontract. For those Subcontractors performing Work under multiple subcontracts, a **separate** **On-Site Payroll Report Information** (TSIB Form 3) is required for **each** Subcontract.

Note:
Failure to submit the payroll report, along with any other CCIP form, may result in the withholding of payments by Turner until required documentation is received.

Change Order Procedures

Enrolled Subcontractors and Sub-subcontractors will price Change Orders to **exclude** their Insurance Cost for CCIP provided coverages and must provide an estimated payroll, including enrolled or eligible Sub-subcontractors estimated payroll amounts for work performed under the Change Order, unless otherwise directed by Turner.

Insurance Company Payroll Audit

Each Enrolled Party is required to maintain payroll records for each Subcontract. Such records will allocate the payroll by Workers' Compensation classification(s) and exclude the excess or premium paid for overtime (i.e., except for projects in the state of Pennsylvania, Nevada, Utah, Delaware and applicable Workers' Compensation monopolistic States, only the straight time rate will apply to overtime hours worked). Furthermore, such records will limit the payroll for Executive Officers and Partners/Sole Proprietors to the limitations as stated in the State manual rules. It is important that you properly classify payrolls, as these are reported to the rating bureau for promulgation of future Experience Modifiers for your firm.

Note:
All Enrolled Parties shall make available their books, vouchers, contracts, documents, payroll

records, certified copies of insurance coverages, declaration pages of coverages, certificates of insurance, underwriting data, insurance cost information, prior loss history information, safety records or history, OSHA citations, or such other data or information as Turner, the CCIP Administrator, CCIP Insurers including the CCIP Insurer Auditors, or other Turner Representative may request in the administration or payroll audit of the CCIP, or as required by this Manual. Availability of records must be for a reasonable time during the policy period, any extension, or during a final audit period as required by the insurance policies.

Modified Alternate Duty Program

Subcontractor and its Sub-subcontractor(s) must provide a modified return to work program for any of its employees injured under Workers' Compensation as part of the CCIP program. **Failure to provide reasonable accommodations will result in a penalty assessment to the Subcontractor of $1,500 weekly until such time as the injured worker is returned to work.** Job expectations are defined as outlined in the Position Description for each Trade. Turner and the CCIP insurer will determine reasonable accommodations.

Claim Reporting

Subcontractor and its Sub-subcontractor(s) must report all injuries, occupational-related illnesses or property damage to the Site Safety Manager immediately. All Parties will instruct employees and other personnel to report, in writing, within 24 hours all Accidents and Occurrences of any type to the Project Site Safety Manager. **Failure to report a claim immediately and a written report submitted within 24 hours of an occurrence may result in a $5,000 penalty.**

CCIP Closeout and Audit Procedures

When a Subcontractor has completed its Work at the Project Site and no longer has on-site workers, or if the CCIP has been terminated, whichever occurs first, submit the **Work Completion Form** (TSIB Form 4). The TSIB Form 4 form will initiate the final audit of payroll and man-hours by the CCIP Insurer. A copy of the Form 4 with instructions for completion is found in Section 8. Should the Subcontractor or any of its Sub-subcontractors return to the Project Site for any reason, they will do so under the Subcontractor's own insurance program. Subcontractor must have previously provided Turner with a Certificate of Insurance showing the Subcontractor's own on-site coverage as detailed in the Subcontract Agreement.

Turner will not release final retention payment until all necessary forms have been submitted and accepted by the CCIP Administrator for Subcontractor and all of its Sub-subcontractors as well as all other requirements of the Subcontract Agreement. Any outstanding General Liability Obligations for which the Subcontractor of any tier is responsible but unpaid will be considered at the time of closeout.

CCIP Termination or Modification

Turner reserves the right to terminate or modify the CCIP or any portion thereof, or modify this Manual, with written notice. If Turner exercises this right, Subcontractors will be provided notice as required by the terms of their individual contracts. At its option, Turner may procure alternate coverage or may require the Subcontractors to procure and maintain alternate insurance coverage.

Upon written notice, Turner may, for any reason, modify the CCIP coverages, discontinue the CCIP, or request that Subcontractor or any of its Sub-subcontractors withdraw from the CCIP. Upon such notice, Subcontractor and/or one or more of its Sub-subcontractors as specified by Turner in such notice, shall obtain and thereafter maintain replacement insurance. The form, content, limits of liability, cost, and the insurer issuing such replacement insurance shall be subject to Turner's approval. The final cost of such insurance shall not exceed the amount of the applicable Subcontractor Insurance Cost, or its pro rata portion, as described elsewhere in this document.

Subcontractor's CCIP Obligations

Subcontractor shall:

(1) Incorporate the terms of this Manual in all Sub-subcontract agreements.

(2) Within five (5) days of execution of the Agreement or no less than forty five (45) days before mobilization, enroll in the CCIP and maintain enrollment in the CCIP, and ensure that Subcontractor's eligible Sub-subcontractors enroll in the CCIP and maintain enrollment in the CCIP within five (5) days of sub-subcontracting or no less than forty five (45) days before mobilization.

(3) Comply with all of the administrative, safety, claims management, insurance, and other requirements outlined in this Manual, the CCIP insurance policies, or elsewhere in the Contract Documents.

(4) Provide each of its Sub-subcontractors with a copy of this Manual and ensure Sub-subcontractor compliance with the provisions of the CCIP insurance policies, this Manual, and the Contract Documents. The failure of (a) Turner to include this Manual in the bid documents, or (b) Subcontractor to provide each of its eligible Sub-subcontractors with a copy of it shall not relieve Subcontractor or any of its Sub-subcontractors from any of the obligations contained therein.

(5) Provide timely evidence of required insurance to Turner.

(6) Accurately and fully complete the Insurance Cost Worksheet (TSIB Form 2) located in this Manual and submit to Turner with Subcontractor's bid (or as required by Turner Purchasing) and prior to commencement of the Work. Along with the completed Form 2, forward copies of WC, GL and Excess and Umbrella rates as more clearly identified in Section 6.

(7) If Subcontractor's initial Price to Turner included insurance coverages provided by the CCIP, Turner shall use Subcontractor's completed TSIB Form 2 and information available to Turner and the CCIP Administrator to calculate Subcontractor's and its Sub-subcontractor's insurance costs due to CCIP insurance coverage ("Subcontractor Insurance Cost"). This Manual outlines the Verified Blended Payroll Rate formula and procedures that Turner will use to calculate the Subcontractor Insurance Cost. Subcontractor is solely responsible for the recovery from its Sub-subcontractors of any Sub-Subcontractor Insurance Cost attributable to such Sub-subcontractors' eligibility for participation in the CCIP. If unit pricing is the basis for the Price, Turner may, at its option, apply a "per unit" Subcontractor Insurance Cost where appropriate.

(8) Notify the CCIP Administrator and Turner's Project Site Superintendent of all Sub-subcontracts awarded (first tier and subsequent tiers). Subcontractor shall cause all Sub-subcontractors to submit a Form 1 Application for Enrollment Form to this end, as well as Form 2, their declaration and rate pages as more clearly identified in this Section 6.

(9) Subcontractor shall identify estimated on-site payroll amount for itself and its enrolled or eligible Sub-subcontractors for its initial contract work. It will also identify additional (or deductive) estimated on-site payroll for each Change Order request.

(10) Acknowledge, and require all of its Sub-subcontractors to acknowledge in writing, that Turner and the CCIP Administrator are not agents, partners or guarantors of the insurance companies providing coverage under the CCIP (each such insurer, a "CCIP Insurer") and that Turner is not responsible for any claims or disputes between or among Subcontractor, its Sub-subcontractors, and any CCIP Insurer(s). Any type of insurance coverage or limits of liability in addition to the CCIP coverages that Subcontractor or any Sub-subcontractor requires for its or their own protection, or that is required by applicable laws or regulations, shall be Subcontractor's or its Sub-subcontractor's sole responsibility and expense and shall not be billed to Turner or the Owner.

(11) Cooperate fully with the CCIP Administrator and the CCIP Insurers, as applicable, in its or their administration of the CCIP.

(12) Notify the CCIP Administrator immediately of any insurance cancellation or non-renewal of your own and Sub-subcontractor required insurance and any subsequent reinstatement of coverage.

(13) At Turner's discretion**, the Subcontractor may be required to pay a sum of up to $5,000 of each occurrence, including court costs, attorney's fees and costs of defense for bodily injury or property damage to the extent losses payable under the CCIP General Liability Policy are**

attributable to Subcontractor's Work, acts or omissions, or the Work, acts or omissions of any of Subcontractor's Sub-subcontractors, or any other entity or party for whom Subcontractor may be contractually or legally responsible ("General Liability Obligation"). The General Liability Obligation shall remain uninsured by Subcontractor and will not be covered by the CCIP Coverages. All monies collected via this obligation will be reinvested into site safety/performance awards.

(14) Turner shall pay the costs of premiums for the CCIP coverages on behalf of all Enrolled Parties. Turner will receive or pay, as the case may be, all adjustments to such costs, whether by way of dividends, retroactive adjustments, return premiums, other moneys due, audits or otherwise. Each Subcontractor and each of its Sub-subcontractors hereby assign to Turner the right to receive all such adjustments. Turner assumes no obligation to provide insurance other than that specified in this Manual and the CCIP insurance policies.

(15) Turner's arranging of CCIP coverages shall in no way relieve or limit, or be construed to relieve or limit, Subcontractor or any of its Sub-subcontractors of any responsibility, liability, or obligation imposed by the Contract Documents or by law, including without limitation any indemnification obligations which Subcontractor or any of its Sub-subcontractors has to Turner thereunder. Turner reserves the right at its option, without obligation to do so, to arrange other insurance coverage of various types and limits provided that such coverage is not less than that specified in the Contract Documents.

Subcontractor Representations and Warranties to Turner

Subcontractor represents and warrants to Turner, on behalf of itself and its Sub-subcontractors:

(1) That all information it submits to Turner or the CCIP Administrator shall be accurate and complete.

(2) That they have had the opportunity to read and analyze copies of the CCIP insurance policies that are on file in Turner's office and that they understand the CCIP coverages. Any reference or summary in the Agreement, this Manual, or elsewhere in any other Contract Document as to amount, nature, type or extent of CCIP coverages and/or potential applicability to any potential claim or loss is for reference only. Subcontractor and its Sub-subcontractors have not relied upon said reference but solely upon their own independent review and analysis of the CCIP coverages in formulating any understanding and/or belief as to amount, nature, type or extent of any CCIP coverages and/or its potential applicability to any potential claim or loss.

Duty of Care

Nothing contained in this Manual shall relieve the Subcontractor or any of its Sub-subcontractors of their respective obligations to exercise due care in the performance of their duties in connection with the Work and to complete the Work in strict compliance with the Contract Documents.

Conflicts

In the event of a conflict, the provisions of the Subcontract Agreement and its other related Contract Documents shall govern, then the provisions of this Manual. In cases of conflict regarding the CCIP coverages provided, the provisions of the policies shall govern.

Safety

Subcontractor shall be solely responsible for safety on the Project. Subcontractor shall establish a safety program that, at a minimum, complies with all local, state and federal safety standards, and any safety standards established by Turner for the Project, including those standards addressed in Turner's "Corporate Safety Manual" dated April 8, 2010, or most recent update, or as otherwise outlined in any Turner site specific safety plan.

Section 7

Claim Procedures

This Section describes basic procedures for reporting various types of Claims: Workers' Compensation, Liability, and damage to the Project.

General Procedures

Subcontractors may be assessed a $5,000 penalty for any claims not reported immediately and a written report submitted within 24 hours of occurrence.

Report all injuries, occupational-related illnesses or property damage to the Site Safety Manager immediately. All Parties will instruct employees and other personnel to report, in writing, within 24 hours ***all*** Accidents and Occurrences of any type to the Site Safety Manager or Project Superintendent.

The Site Safety Manager or Project Superintendent contact information can be found in Section 2 of this Manual.

While all injuries and property damage must be reported immediately, the following list identifies losses which could represent substantial exposure. It is essential that the Site Safety Manager or the Project Superintendent be notified immediately so that a comprehensive investigation can be initiated at once.

Immediately call the Site Safety Manager or Project Superintendent in the event of the following:

- Any injury for which an ambulance is called
- Injury to head or neck
- Possible injury to back or spinal cord
- Unconscious employee
- Possible blindness
- Amputation of limbs
- Fatality
- Heart attack or stroke
- Hospitalization
- Property damage estimated over $1,000

Investigation Assistance

All Parties will assist in the investigation of any accident or occurrence involving injury to persons or property. All Parties will cooperate with authorized companies by securing and giving evidence and obtaining the participation and attendance of witnesses required for the adjustment, investigation and defense of any claim or suit.

Workers' Compensation Claims

All Claims MUST immediately be reported to the Site Safety Manager.

The main responsibility for any Party is first to see that the injured worker receives immediate medical care. Next, you should immediately notify the Site Safety Manager.

Subcontractors' on-site personnel will follow these procedures if any employee is involved in an accident or occurrence resulting in bodily injury:

1. Contact designated first aid/medical personnel and transport the injured party to the on-site first aid or medical facility, as necessary.

2. Report all injuries or occupational-related illnesses immediately to the Employer's Project Supervisor and Turner's Site Safety Manager or Site Superintendent.
3. Employer must complete a *Supervisor's Accident Investigation Report* and return to Turner's Site Safety Manager within 24 hours of employee's notice of injury/claim. The Turner Site Safety Manager will fax/mail the completed form to the Turner Claims Manager within 24 hours of receipt.
4. Supply the Injured Party with a Medical Information Claim Folder which shall include a Doctor's Initial Report Form, Turner's 90 Day Modified Alternate Duty Program, Position Description and a Medical Authorization Form which are to be returned by the Injured Party to the Turner Site Safety Manager by the end of the business day. *(Please see pages 57 – 62 for all appropriate forms relative to the Return to Work Program).*
5. Subcontractor and its Sub-subcontractor will provide for Modified Alternate Duty based upon the work abilities given to the Injured Party from the treating physician.
6. Immediately send all subsequent medical return to work notes, inquiries or correspondence about an Injured Party to the Turner Site Safety Manager.
7. No Injured Party will be allowed on a job site unless they have provided the Turner Site Safety Manager with the proper return to work note, either full duty or modified duty.
8. California Workers' Compensation Medical Provider Network Information.

Medical Provider Network for the State of California

Liberty Mutual Group

IMPORTANT INFORMATION REGARDING YOUR WORKERS COMPENSATION BENEFITS

MEDICAL TREATMENT FOR WORK RELATED INJURIES

This letter serves as a notification and a reminder about the Liberty Mutual Group Medical Provider Network (MPN) and contains important information regarding workers compensation benefits and medical treatment for work related injuries.

Recent changes in California's workers' compensation laws now allow insurers and self-insured employers to direct injured employees to a medical provider network (MPN) for medical treatment if they receive state approval for the network.

The State of California has certified the Liberty Mutual Group Medical Provider Network (MPN) under California Labor Code section 4616 et seq. and Division of Workers' Compensation regulations to provide all necessary medical care, treatment and services for your work related injury.

The goals of the MPN program are to ensure that:

- You have access to prompt, efficient, and quality medical care, treatment and services for occupational injuries and illnesses.
- You have increased access to occupational health services and specialists.
- You receive ongoing medical review of treatment.

All rendered treatment will be consistent with recommended standards set forth in the American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, evidence based medical guidelines or with guidelines adopted by the DWC Administrative Director.

You may pre-designate your physician(s) prior to injury if:

- You have received care with the physician, and
- The physician agrees to be your primary treating physician.

If your physician does not agree to participate in this capacity, you will be required to seek medical care with a MPN provider.

Access to MPN Services

The MPN shall ensure that a MPN primary care physician, a hospital, or a provider of all emergency health care services are located within thirty (30) minutes or fifteen (15) miles from your residence or work place. Other occupational health services and specialists must be within sixty (60) minutes or thirty (30) miles from your residence or work place. You may consult with your employer for physician, hospital or other medical care recommendations within the MPN.

Should you have a work-related injury, your supervisor will help to ensure that you receive prompt initial care and medical attention through a MPN provider.

- On the job injuries must immediately be reported to your supervisor.

"Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purposes of obtaining or denying workers' compensation benefits or payments is guilty of a felony"

- Upon being notified of an on the job injury, your supervisor will immediately direct you to a primary care MPN physician who will provide you with the necessary initial and subsequent medical care required for your injury. At the time of your referral for initial care, you will be informed of your right after your initial visit with a MPN provider to be treated by a physician of your choice within the MPN and how to obtain a directory of available MPN providers.
- The Liberty Mutual Group MPN physician/provider directory will be available to your employer, physician and you. You may contact your supervisor or Claims Case Manager to request a regional and/or full listing of the MPN provider network. Your employer or Claims Case Manager will provide you the options of receiving (a) an internet link and password to electronically access a regional and/or full listing of the MPN provider network via the Provider Referral Services (PRS) system; (b) a printed copy of the regional and/or full listing of the MPN provider network; and/or (c) a printed copy of a regional and or full listing of MPN providers by calling either the Liberty Provider Referral Line, 1-800-944-0443 or the Wausau Provider Referral line, 1-888-398-6333."
- If you need emergency health care services, please proceed to the nearest hospital or emergency medical facility and notify your employer immediately but no later than within 48 hours of treatment. The Liberty Mutual Group MPN shall allow the emergency health care services by the hospital or medical facility until such time that your physician considers you to be in stable medical condition and recommends that you may return to your residence or your employer's workplace. You will then continue your medical treatment with a MPN physician or provider under the provisions of the Liberty Mutual Group MPN.
- For non-emergency services, an appointment for initial treatment with a MPN physician will be available within three (3) business days of your request for treatment. For non-emergency specialist services to treat common injuries experienced at work, an appointment with a specialist within the MPN will be available within twenty (20) business days of your request for a referral.

If you are temporarily working or traveling for work and require treatment outside the MPN service area and need emergency health care services proceed as stated above. If you require non-emergency medical treatment outside of the MPN service area, you should notify your supervisor of your need for medical treatment outside the MPN Service Area. The Claims Case Manager will assist you, if necessary, in obtaining appropriate medical treatment from a physician or other providers outside the MPN service area.

- If you require medical treatment in certain rural or unpopulated areas where health facilities are located at least 30 miles apart, you must notify your employer or Claims Case Manager. You may need to treat with a physician or provider outside of the MPN service area. If necessary, the Claims Case Manager will provide you with a MPN provider directory.
- If your physician prescribes durable medical equipment, home health services, or medications for you, please contact your Claims Case Manager who will contact the ancillary service provider. The service provider will contact you directly to arrange for service delivery.
- If you need transportation to your MPN physician or medical facility please contact your Claims Case Manager who will make the necessary arrangements. The service provider will contact you directly to arrange for service delivery.
- If you need language translation services provided to you at the time of your medical appointment please contact your Claims Case Manager who will make the necessary arrangements. The service provider will contact you directly to arrange for service delivery.

"Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purposes of obtaining or denying workers' compensation benefits or payments is guilty of a felony"

Changing Your Treating Physician Within the MPN

- If you are not satisfied with the services of a MPN provider anytime after your initial medical evaluation, you will be allowed to change to another provider of your choice within the MPN.
- Non-emergency treatment, incurred outside of the MPN may not be paid unless the request is received by a Claims Case Manager, in advance. This written request should also document the reason for the requested change.

Your supervisor or the Claims Case Manager can assist you in choosing a geographically convenient provider in the MPN and will be able to assist you to ensure that you receive the appropriate medical attention needed to get you back to work.

If you have difficulty scheduling an appointment with a MPN physician or provider you should notify the Claims Case Manager. The Claims Case Manager will contact the physician or provider on your behalf to schedule an appointment. If the physician or provider cannot accommodate your appointment request within the required timeframes the Claims Case Manager will notify you and when necessary, will provide to you a full listing and/or regional MPN directory of the names of physicians or providers who are accessible to you for you to choose another physician or provider.

Transfer of Ongoing Medical Care to MPN Provider

If you are currently being treated for a work related injury or illness by a physician or other health care provider that becomes a provider in the MPN, you may continue treatment with your physician or health care provider through the MPN.

If you are being treated for a work related injury or illness by a physician or other health care provider that is not in the MPN, you may continue to receive treatment from your physician or provider for the duration of any acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a duration of not more than 30 days. Completion of treatment shall be provided for the duration of the acute condition.

For a serious chronic condition, you may complete treatment with your physician or other health care provider that is not in the MPN for a period of time, up to one year, necessary to complete the course of treatment approved by your insurer or employer and to arrange transfer to another provider within the MPN, as determined by your insurer or employer. A serious chronic condition is a medical condition due to disease, illness, catastrophic injury, or other medical problem or medical disorder that is serious in nature that persists without full cure or worsens over 90 days and requires ongoing treatment to maintain remission or prevent deterioration. The one year period for completion of treatment starts from the date of determination that the employee has a serious chronic condition.

You will continue to have coverage and may complete treatment with your physician or other health care provider that is not in the MPN for an incurable or irreversible condition for the duration of a terminal illness which is defined as an incurable or irreversible condition that has a high probability of causing death within one year or less.

You may have surgery or other procedures performed by your physician or other health care provider that is not in the MPN that were authorized by your Claims Case Manager or employer and were recommended and documented by your physician or other health care provider to occur within one hundred and eighty (180) days from the effective date of the MPN.

"Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purposes of obtaining or denying workers' compensation benefits or payments is guilty of a felony"

Your Claims Case Manager or employer will notify you and your primary treating physician in writing of the determination regarding completion of ongoing treatment. You may request a report from your treating physician if you disagree with the determination regarding transfer of ongoing care. If you disagree with the medical determination made by your treating physician regarding transfer of care, you may file a dispute under Labor Code section 4062. The transfer of care will go forward during the dispute resolution process only if your treating physician agrees with your MPN or employer's determination.

Treatment Provided By A Specialist

If you require treatment by a specialist, you may self-select an appropriate specialist or be referred to a specialist by your physician. Your Claims Case Manager can provide you with a full listing of the MPN provider network or a regional directory of the names of physicians or providers who are accessible to you within 60 minutes or 30 miles of your residence or workplace. Your physician has access to the MPN directory and can also refer you to a specialist within the MPN.

MPN Continuing Care Policy

As a covered employee in the MPN you have certain rights concerning your medical care. Your rights include allowing you to receive and complete medical treatment for certain medical conditions with your physician who may not be in the MPN. If your physician is terminated from the MPN, on a case-by-case basis, you may be allowed to treat with a specialist who is not within the MPN. A copy of the MPN Continuing Care Policy is available from your Claims Case Manager.

Procedures for Selecting a Physician for a Second and Third Opinion

If you dispute either the diagnosis or treatment prescribed by your treating physician, you may obtain a Second Opinion and a Third Opinion from other physicians within the MPN. During this process you have the option to continue ongoing treatment with your treating physician or change to another physician of your choice within the MPN pursuant to section 9767.6 of the Department of Workers' Compensation regulations.

A Second Opinion is an opinion rendered by a MPN physician, after an in person examination, to address a dispute that you have over either the diagnosis or the treatment prescribed by your treating physician.

A Third Opinion is an opinion rendered by a MPN physician, after an in person examination, to address a dispute that you have over either the diagnosis or the treatment prescribed by either your treating physician or the physician that rendered a Second Opinion.

To obtain a Second Opinion, you must inform your supervisor or your Claims Case Manager verbally or in writing by letter, fax or electronic mail that you dispute your treating physician's opinion and are requesting a Second Opinion. You may select a physician or specialist from a directory of available MPN providers provided to you by the Claims Case Manager for the Second Opinion. It is your responsibility to make the appointment with the Second Opinion physician within sixty (60) days and inform the Claims Case Manager of the appointment date. The Claims Case Manager will contact the Second Opinion provider in writing to notify that he or she has been selected for a Second Opinion, to describe the nature of the dispute, and provide necessary medical records prior to the appointment date. You will receive a copy of the letter to the Second Opinion physician. Upon your request, you may obtain a copy of your medical records. If the appointment is not made within sixty (60) days of your receipt of the directory of available MPN providers, then you may not obtain a Second Opinion for the disputed diagnosis or treatment of your treating physician. You and your treating physician will receive a copy of the Second Opinion physician's written report within twenty (20) days of the date of your appointment or the receipt of results of any diagnostic tests made at your appointment, whichever is later.

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To obtain a Third Opinion, you must inform your supervisor or your Claims Case Manager verbally or in writing by letter, fax or electronic mail that you dispute the second opinion physician's diagnosis or treatment and are requesting a Third Opinion. You may select a physician or specialist from a directory of available MPN providers provided to you by the Claims Case Manager for the Third Opinion. At the time of the selection of the physician for a third opinion, the Claims Case Manager will notify you about the Independent Medical Review process and provide you with an "Application for Independent Medical Review" form as set forth in section 9768.10 of the Department of Workers Compensation regulations. The Claims Case Manager will fill out the "MPN Contact Section" of the form and list the specialty of the treating physician and an alternative specialty, if any, that is different from the specialty of the treating physician.

It is your responsibility to make the appointment with the Third Opinion physician within sixty (60) days and inform the Claims Case Manager of the appointment date. The Claims Case Manager will notify the Third Opinion provider in writing that he or she has been selected for a Third Opinion, describe the nature of the dispute, and provide necessary medical records prior to the appointment date. You will receive a copy of the letter to the Third Opinion physician. Upon your request, you may obtain a copy of your medical records. If the appointment is not made within sixty (60) days of your receipt of a directory of available MPN providers, then you may not obtain a Third Opinion for the disputed diagnosis or treatment of your treating physician. You and your treating physician will receive a copy of the Third Opinion physician's written report within twenty (20) days of the date of your appointment or the receipt of results of any diagnostic tests made at your appointment, whichever is later.

If you disagree with the diagnosis or treatment recommended by the Third Opinion physician, you may file the application form with the California Division of Workers' Compensation Administrative Director to request an Independent Medical Review. If you need assistance contact your supervisor or your Claims Case Manager.

Contact Information

For questions and concerns regarding the MPN program contact your supervisor, the Claims Case Manager, or the Liberty Mutual Group MPN Program Coordinator. The Claims Case Manager and the MPN Program Coordinator may be contacted during normal business hours of 8:00 AM - 5:00 PM PST, Monday through Friday. The MPN Program Coordinator may be contacted at 559-435-2144 x355. The Liberty Mutual Utilization Review Unit may be contacted during normal business hours of 8:30 AM - 6:30 PM PST Monday through Friday at 1-800-664-CARE (2273).

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Red de Profesionales de Servicios Médicos para el Estado de California

Grupo Liberty Mutual

INFORMACIÓN IMPORTANTE ACERCA DE LOS BENEFICIOS DE COMPENSACIÓN DE SUS TRABAJADORES

TRATAMIENTO MÉDICO PARA LESIONES RELACIONADAS CON EL TRABAJO

Notificación de la Grupo Liberty Mutual Red de Profesionales de Servicios Médicos para el Estado de California

Esta carta sirve como una notificación y recuerdo sobre el Grupo Liberty Mutual Red de Profesionales de Servicios Médicos (MPN) y contiene la información importante acerca de los beneficios de compensación de trabajadores lesionados y el tratamiento médico para lesiones relacionadas con el trabajo

Los recientes cambios en las leyes de compensación de los trabajadores de California permiten ahora que las aseguradoras y los empleadores auto-asegurados envíen a los trabajadores lesionados a una red de profesionales de servicios médicos (medical provider network o MPN) para su atención si el estado les otorga la aprobación de esa red.

El Estado de California ha certificado a la Red de Profesionales de Servicios Médicos (MPN) del Grupo Liberty Mutual conforme al Código de Trabajo de California (California Labor Code) sección 4616 y subsecuentes, y a los reglamentos de la División de Regulaciones de Indemnización a Trabajadores (Division of Workers' Compensation o DWC) para proporcionar toda la atención médica, tratamiento y servicios necesarios para su lesión relacionada con el trabajo.

Los objetivos del programa MPN son asegurar que:

- Usted tenga acceso a atención y servicios médicos rápidos, eficientes y de calidad para lesiones de trabajo y enfermedades.
- Tenga mayor acceso a servicios de salud y especialistas de la salud de trabajo.
- Reciba revisión médica progresiva del tratamiento.

Todo tratamiento que se proporcione será consistente con los estándares recomendados establecidos en los Lineamientos de la Práctica de la Medicina del Trabajo del Colegio Americano de Medicina Profesional y Ambiental (American College of Occupational and Enviromental Medicine o ACOEM) y en lineamientos médicos basados en la experiencia o los adoptados por el Director Administrativo de la DWC.

Usted puede predesignar a su(s) médico(s) antes de la lesión si:

- Ha recibido atención del médico y
- él/ella está de acuerdo en ser el médico que lo atienda principalmente.

Si su médico no está de acuerdo en participar de esta forma, se le pedirá que busque la atención médica de un profesional de la MPN acceso a los Servicios de la MPN

La MPN se asegurará que haya un médico de atención primaria de la MPN, un hospital o un profesional de todos los servicios de atención a la salud localizado a no más de treinta (30) minutos o quince (15) millas de su domicilio o lugar de trabajo. Otros servicios y especialistas de salud de trabajo deben estar a

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no más de sesenta (60) minutos o treinta (30) millas de su domicilio o lugar de trabajo. Usted puede consultar a su supervisor, para que le recomiende un médico, un hospital o le hagan otras recomendaciones sobre atención médica dentro de la MPN:

En caso de que usted tenga una lesión relacionada con el trabajo, su supervisor le ayudará a asegurarse que usted reciba atención inicial rápida y atención médica a través de un profesional de la MPN.

- Las lesiones en el trabajo deben reportarse inmediatamente a su supervisor.
- Al momento en que se le notifique una lesión de trabajo, su supervisor lo referirá de inmediato a un médico de atención primaria de la MPN quien le proporcionará la atención médica inicial y subsecuente que su lesión amerita. Al momento en que se le refiera para la atención inicial, se le informará de su derecho, después de una visita inicial con un profesional de la MPN, a ser tratado por el médico de su elección dentro de la MPN y cómo obtener un directorio de profesionales MPN disponibles.
- El directorio de médicos y profesionales de la MPN de Grupo Liberty Mutual estará disponible para su empleador, su médico y usted. Puede comunicarse con su supervisor o Administrador de Casos de Reclamación para solicitar un listado regional y/o completo de la red de proveedores de la MPN. Su empleador o el Administrador de Casos de Indemnización le proporcionará las opciones para recibir (a) un vínculo de Internet y una contraseña para tener acceso electrónico a un listado regional y/o completo de la red de proveedores de la MPN a través del sistema de Servicios de Referencia de Proveedores (PRS); (b) una copia impresa del listado regional y/o completo de la red de proveedores de la MPN; y/o (c) una copia impresa de un listado regional y/o completo de proveedores de la MPN al llamar a la Línea de Referencia de Proveedores Liberty, 1-800-944-0443 o la línea de Referencia de Proveedores Wausau, 1-888-398-6333.
- Si necesita servicios de atención a la salud de emergencia, por favor acuda al hospital más cercano o instalación médica de emergencia y comuníquese con su empleador inmediatamente, en un plazo que no exceda las 48 horas siguientes al tratamiento. La MPN del Grupo Liberty Mutual permitirá los servicios de atención a la salud en el hospital o instalación médica hasta que su médico considere que usted se encuentra estable y le recomiende regrese a su domicilio o al lugar de trabajo de su empleador. Entonces usted continuará su tratamiento médico con un médico o profesional de la MPN de acuerdo con las condiciones de la MPN del Grupo Liberty Mutual.
- Para los servicios que no sean de emergencia, se le dará cita para tratamiento inicial con un médico de la MPN dentro de los tres (3) días hábiles siguientes a su solicitud de tratamiento. Para los servicios que no sean de emergencia de un especialista para tratar lesiones comunes en el trabajo, se le dará cita con un especialista de la MPN dentro de los veinte (20) días hábiles siguientes a su solicitud de tratamiento.
- Si usted está trabajando temporalmente o en viaje de negocios y requiere tratamiento fuera del área de servicio de la MPN y requiere atención médica de emergencia proceda como se indicó arriba. Si usted requiere tratamiento médico que no sea de emergencia fuera del área de servicio de la MPN, usted debería notificar a su supervisor sobre su necesidad de recibir tratamiento médico fuera del área de servicio de la MPN. El Administrador de Casos de Indemnización lo ayudará, en caso de ser necesario, a obtener tratamiento médico adecuado por parte de médicos y profesionales fuera del área de servicio de la MPN.
- Si requiere tratamiento médico en ciertas áreas rurales o poco pobladas en donde las instalaciones sanitarias se encuentran apartadas entre si al menos a 30 millas de distancia, debe notificarlo a su empleador o a su Administrador de Casos de Indemnización. Usted podría tener que tratar con un médico o profesional fuera del área de servicio de la MPN. Si es necesario, el Administrador de Casos de Indemnización le proporcionará un directorio de profesionales de la MPN.

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- Si su médico le prescribe equipo médico durable, servicios de salud a domicilio o medicamentos, por favor comuníquese con su Administrador de Casos de Indemnización quien hará lo propio con el profesional de servicio auxiliar. El profesional de servicio se comunicará directamente con usted para acordar la entrega del servicio.

- Si necesita transporte para ir a su médico o instalación médica de la MPN por favor comuníquese con su Administrador de Casos de Indemnización quien hará los arreglos necesarios. El profesional de servicio se comunicará directamente con usted para acordar la entrega del servicio.

Si necesita servicios de interpretación de idiomas al momento de su cita médica por favor comuníquese con su Administrador de Casos de Indemnización quien hará los arreglos necesarios. El profesional de servicio se comunicará directamente con usted para acordar la entrega del servicio.

Cambio de médico dentro de la MPN

- Si usted no está satisfecho con los servicios de un profesional de la MPN en cualquier momento después de su evaluación médica inicial, se le permitirá cambiar a otro profesional de su elección dentro de la MPN.

- El tratamiento que no sea de emergencia fuera de la MPN puede no ser pagado a menos que el Administrador de Casos de Indemnización reciba la solicitud previamente. Dicha solicitud escrita también debe documentar la razón para el cambio solicitado.

Su supervisor o el Administrador de Casos de Indemnización pueden ayudarle a elegir un profesional geográficamente conveniente en la MPN y podrá ayudarle a asegurar que usted reciba la atención médica adecuada que necesita para que vuelva al trabajo.

Si usted tiene alguna dificultad para concertar una cita con un médico o profesional de la MPN deberá notificarlo al Administrador de Casos de Indemnización. El Administrador de Casos de Indemnización se comunicará con el médico o profesional por usted para concertar una cita. Si el médico o profesional no puede acomodar su cita dentro de los límites de tiempo, el Administrador de Casos de Indemnización se lo hará saber y, si es necesario, le proporcionará un listado regional y/o completo de la red de proveedores de la MPN de los nombres de los médicos o profesionales que están disponibles para que usted elija otro médico o profesional.

Transferencia de la atención médica actual a un profesional de la MPN

Si usted está siendo tratado actualmente por una lesión o enfermedad relacionada con el trabajo por un médico u otro profesional de atención a la salud que se convierta en un profesional en la MPN, usted puede continuar su tratamiento con su médico o profesional de atención a la salud a través de la MPN.

Si usted está siendo tratado actualmente por una lesión o enfermedad relacionada con el trabajo por un médico u otro profesional de atención a la salud que no esté en la MPN, usted puede continuar recibiendo tratamiento de su médico o profesional mientras haya alguna condición grave. Una condición grave es una condición médica que incluya una serie repentina de síntomas debidos a una enfermedad, lesión u otro problema médico que requiera atención médica rápida y que tenga una duración de no más de 30 días. Se proporcionará el tratamiento mientras dure la condición grave.

Para una condición crónica seria, usted puede completar el tratamiento con su médico o algún otro profesional de atención a la salud que no esté en la MPN por un período de tiempo, hasta un año, necesario para completar el curso del tratamiento aprobado por su aseguradora o empleador y para hacer la transferencia a otro profesional dentro de la MPN, como lo determina su aseguradora o empleador. Una condición crónica seria es una condición médica debida a un padecimiento, enfermedad, lesión catastrófica u otro problema médico o desorden médico que es de naturaleza seria y que persiste sin curarse totalmente o empeora durante 90 días y requiere tratamiento progresivo para mantener la remisión o prevenir el deterioro. El período de un año para que se complete el tratamiento comienza desde la fecha en que se determina que el empleado tiene una condición crónica seria.

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Usted seguirá teniendo cobertura y puede completar el tratamiento con su médico u otro profesional de atención a la salud que no esté en la MPN para una condición incurable o irreversible por la duración de la enfermedad terminal que se define como una condición incurable o irreversible que tenga una alta probabilidad de causar la muerte dentro de un año o menos.

Su médico u otro profesional de atención a la salud que no esté en la MPN, que haya sido autorizado por su Administrador de Casos de Indemnización o su empleador y que haya sido recomendado y documentado por su médico u otro profesional de atención a la salud, puede practicarle cirugía u otros procedimientos dentro de los ciento ochenta (180) días siguientes a la fecha efectiva de la MPN.

Su Administrador de Casos de Indemnización o su empleador le notificarán a usted y al médico que lo atiende principalmente por escrito de la determinación sobre la continuación del tratamiento actual. Usted puede solicitar un reporte del médico que lo trata si no está de acuerdo con la determinación sobre la transferencia de la atención actual. Si usted no está de acuerdo con la determinación médica que hizo el médico que lo atiende sobre la transferencia de la atención usted puede presentar una disputa bajo el Código de Trabajo sección 4062. La transferencia de la atención continuará durante el proceso de resolución de la disputa sólo si su médico está de acuerdo con la determinación de la MPN o de su empleador.

Tratamiento proporcionado por un especialista

Si usted requiere tratamiento de un especialista, usted puede seleccionar por sí mismo a un especialista apropiado o su médico puede referirle a un especialista. Su Administrador de Casos de Indemnización puede proporcionarle un listado completo de la MPN o un directorio regional de nombres de médicos o profesionales que están disponibles para usted a 60 minutos o 30 millas de su domicilio o lugar de trabajo. Su médico tiene acceso al directorio de la MPN y puede referirle a un especialista.

Política de atención continúa de la MPN

Como empleado cubierto en la MPN usted tiene ciertos derechos referentes a su atención médica. Sus derechos incluyen permitirle recibir y completar el tratamiento médico para ciertas condiciones médicas con su médico quien puede no estar en la MPN. Si su médico es quitado de la MPN, dependiendo del caso, se le puede permitir a usted que trate con un especialista que no está dentro de la MPN. Hay una copia de la Política de Atención Continua disponible con su Administrador de Casos de Indemnización.

Procedimientos para seleccionar a un médico para una segunda y tercera opinión

Si usted presenta una disputa, ya sea por el diagnóstico o el tratamiento que le prescribió el médico que lo trata, usted puede obtener una Segunda Opinión y una Tercera Opinión de otros médicos dentro de la MPN. Durante este proceso usted tiene la opción de continuar con su tratamiento actual con el médico que lo trata o cambiar a otro médico de su elección dentro de la MPN de conformidad con la sección 9767.6 del reglamento del DWC.

Una Segunda Opinión es una opinión proporcionada por un médico de la MPN, después de un examen en persona, para atender una disputa que usted tenga, ya sea sobre el diagnóstico o sobre el tratamiento que le prescribió el médico que lo trata.

Una Tercera Opinión es una opinión proporcionada por un médico de la MPN, después de un examen en persona, para atender una disputa que usted tenga, ya sea sobre el diagnóstico o sobre el tratamiento que le prescribió ya sea el médico que lo trata o el médico que proporcionó una Segunda Opinión.

Para obtener una Segunda Opinión usted debe informar a su supervisor o su Administrador de Casos de Indemnización verbalmente o por escrito, fax o correo electrónico que usted pone en disputa la opinión del médico que lo trata y que está solicitando una Segunda Opinión. Usted puede seleccionar a un médico o especialista de un directorio de profesionales MPN disponibles que le proporcione el Administrador de

Casos de Indemnización para la Segunda Opinión. Es su responsabilidad concertar la cita con el médico de la Segunda Opinión dentro de los sesenta (60) días siguientes e informar al Administrador de Casos de Indemnización de la fecha de la cita. El Administrador de Casos de Indemnización se comunicará con el profesional de la Segunda Opinión por escrito para notificarle que ha sido seleccionado para una Segunda Opinión, para describirle la naturaleza de la disputa y proporcionar el historial médico necesario antes de la fecha de la cita. Usted recibirá una copia de la carta al médico de la Segunda Opinión. Si usted lo solicita, usted puede obtener una copia de su historial médico. Si no se hace la cita dentro de los sesenta (60) días siguientes a que usted reciba el directorio de profesionales MPN disponibles, usted no podrá obtener una Segunda Opinión del diagnóstico o tratamiento en disputa del médico que lo trata Usted y el médico que lo trata recibirán una copia del reporte escrito del médico de la Segunda Opinión dentro de los veinte (20) días siguientes a la fecha de su cita o la recepción de los resultados de cualquier prueba diagnóstica que se haya hecho en su cita, lo que suceda después.

Para obtener una Tercera Opinión usted debe informar a su supervisor o su Administrador de Casos de Indemnización verbalmente o por escrito, fax o correo electrónico que usted pone en disputa el diagnóstico o el tratamiento del médico de la segunda opinión y que está solicitando una Tercera Opinión. Usted puede seleccionar a un médico o especialista de un directorio de profesionales MPN disponibles que le proporcione el Administrador de Casos de Indemnización para la Tercera Opinión. Al momento de la selección de un médico para obtener la Tercera Opinión, el Administrador de Casos de Indemnización le notificará acerca del procedimiento de Revisión Médica Independiente y le proporcionará un formulario de "Solicitud de Revisión Médica Independiente" como lo dispone la sección 9768.10 del reglamento de la DWC. El Administrador de Casos de Indemnización completará la "Sección de Contacto de la MPN" del formulario y anotará la especialidad del médico tratante y una especialidad alternativa, si la hay, distinta a la especialidad del médico tratante.

Es su responsabilidad concertar la cita con el médico de la Tercera Opinión dentro de los sesenta (60) días siguientes e informar al Administrador de Casos de Indemnización de la fecha de la cita. El Administrador de Casos de Indemnización se comunicará con el profesional de la Tercera Opinión por escrito para notificarle que ha sido seleccionado para una Tercera Opinión, para describirle la naturaleza de la disputa y proporcionar el historial médico necesario antes de la fecha de la cita. Usted recibirá una copia de la carta al médico de la Tercera Opinión. Si usted lo solicita, usted puede obtener una copia de su historial médico. Si no se hace la cita dentro de los sesenta (60) días siguientes a que usted reciba la lista de profesionales MPN disponibles, usted no podrá obtener una Tercera Opinión del diagnóstico o tratamiento en disputa del médico que lo trata Usted y el médico que lo trata recibirán una copia del reporte escrito del médico de la Tercera Opinión dentro de los veinte (20) días siguientes a la fecha de su cita o la recepción de los resultados de cualquier prueba diagnóstica que se haya hecho en su cita, lo que suceda después.

Si usted no está de acuerdo con el diagnóstico del tratamiento recomendado por el médico de la Tercera Opinión, puede presentar un formulario de solicitud dirigido al Director Administrativo de la División de Compensación a Trabajadores de California para solicitar una Revisión Médica Independiente. Si necesita ayuda, comuníquese con su supervisor o su Administrador de Casos de Indemnización.

Información de contacto

Si tiene preguntas o inquietudes acerca del programa MPN comuníquese con su supervisor, con el Administrador de Casos de Indemnización o el Coordinador de Programas de la MPN del Grupo Liberty Mutual. Usted puede comunicarse con el Administrador de Casos de Indemnización y el Coordinador de Programas durante las horas normales de oficina de 8:00 AM a 5:00 PM PST, de lunes a viernes. Puede comunicarse con el Coordinador de Programas de la MPN al teléfono 559-435-2144 ext. 355. Usted puede comunicarse con la Unidad de Revisión de Utilización de Liberty Mutual durante las horas normales de oficina de 8:30 AM a 6:30 PM PST de lunes a viernes al teléfono 1-800-664-CARE (2273).

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Liability Claims

Immediately Report all Liability claims to the Site Safety Manager.

Subcontractors must immediately report all Accidents at the Project Site involving death, injury, or damage to property of non-employee personnel (the public, tenants, and visitors) to the Turner Site Safety Manager or Turner Superintendent. As soon as the on-site personnel become aware of the accident or occurrence, they must:

1. Take appropriate emergency measures to prevent additional injury or damage, including contacting police and fire authorities.
2. Complete and submit a *Supervisor's Accident Investigation Report and General Liability Loss Notice* to the Turner Site Safety Manager within 24 hours of the incident.
3. Immediately send all subsequent inquires or correspondence about an insured loss or claim, including a summons or other legal documents, to the Site Safety Manager immediately.

Do *not* voluntarily admit liability or responsibility. Cooperate with Turner and the CCIP insurer representatives in the accident investigation. Do not discuss the accident with anyone other than Turner Personnel, CCIP insurer representatives, or legal counsel retained on our behalf.

Property Claims

Report all Property claims to the Turner Site Safety Manager.

Immediately Report any damages to your Work or the Work of any other Subcontractor to the Project Site Safety Manager.

Automobile Claims

Report all Auto claims to your insurance carrier and the Turner Site Safety Manager.

No coverage is provided for automobile accidents under the CCIP. It is the sole responsibility of each Party to report accidents/claims involving their automobiles to their own insurers.

HOWEVER, all accidents occurring in or around the Project site must be reported to Turner's Site Safety Manager. Accident investigations will occur and focus on liability arising out of the Project construction activities that could result in future claims (i.e. due to the conditions of the roads, etc.). Each Party shall cooperate in the investigation of all automobile accidents.

Pollution Claims

The CCIP general liability policy may provide some coverage for sudden and accidental pollution ***but only if the incidents are discovered and reported promptly in writing.*** Report claims by immediately notifying the Turner Site Safety Manager of any known or suspected pollution incidents.

Joint Representation

In the event legal representation is required to defend parties insured under this CCIP, absent an actual conflict of interest between two or more insureds, the insurer shall have the right to retain one counsel to represent all such insureds in any action or proceeding in which more than one insured is joined.

An insured has an actual conflict, and is entitled to separate counsel, only in the following circumstance:

a. the CCIP insurer has issued a reservation of its rights to one, but not all, insureds joined in such action or proceeding,

b. a CCIP insurer's reservation of rights issued to one insured contains reservations different that an reservation issued to another insured(s) joined in such action or proceeding; or

c. adequate, unexhausted limits of CCIP insurance are not available for the damages sought in such action or proceeding.

Any insured with an actual conflict of interest may waive that conflict.

Enrollment in this CCIP program shall be deemed a waiver of any conflict which does not meet the above definition of an actual conflict. As a condition of enrollment in this CCIP program, all insureds agree to perform any additional acts required to effectuate the waiver of any conflict which does not meet the above definition of an actual conflict.

Waiver of Insured Cross-Claims

As a condition of enrollment in this CCIP program, no insured shall be entitled to make a cross-claim (or any similar legal claim) against another insured if that cross-claim arises from "bodily injury", "property damage" or "personal injury" to which this CCIP's insurance applies and for which there is adequate unexhausted limits of insurance to pay damages in any such proceeding. Enrollment in this CCIP program shall be deemed a waiver of such claims. As a condition of enrollment in this CCIP program, all insureds agree to perform any additional acts required to effectuate the waiver of any such claim. This paragraph shall not apply to any suit or claim necessary to trigger CCIP coverage.

Availability of Claims Data

Turner has made claims data available to all CCIP enrolled parties. Data is accessible through the Vue WrapUp application (program administration software). Claim data is updated no less than quarterly. Claims are associated with your contract.

If you need a User ID and Password to access the Vue WrapUp, please contact the Quality Assurance Specialist listed in Section 2, CCIP Project Directory, at (866) 684-WRAP and follow the prompts, **OR** send an email to WrapUP@tsibinc.com. Please include your full name, employer's company name, the name of each project, and each contract number.

Please direct all claim related questions to the Turner Claim Coordinator/Claim Manager listed in Section 2, CCIP Project Directory.

Section 8

Forms

This Section contains the forms needed for administration of the CCIP.

TSIB Form 1	Application For Enrollment
TSIB Form 2	Insurance Cost Worksheet
TSIB Form 3	On-Site Payroll Report Information
TSIB Form 4	Work Completion Form
Exhibit 1	SAMPLE ENROLLED PARTY Certificate of Insurance
Exhibit 2	SAMPLE EXCLUDED PARTY Certificate of Insurance
GL Claim Form	Report of General Liability Accident
WC Claim Form	Report of Workers' Compensation Accident
WC Form 1	Turner's 90 Day Modified Alternate Duty Program
WC Form 2	Doctor's Initial Report Form
WC Form 3	Position Description
WC Form 4	Medical Authorization Form

Note:

For assistance in completing the TSIB Form 1 through TSIB Form 4, please contact the Turner Surety And Insurance Brokerage Wrap-up Service

Phone: (866) 684-WRAP
(866) 684-9727
(203) 283-2000

Email: WrapUp@tsibinc.com

This application is used by the insurance company to produce your Workers' Compensation policy as well as confirming GL coverage on the project. Please note that coverage will only apply for work done at the named project. It is extremely important for you to complete this form and send to TSIB, the Wrap-Up Administrator before you begin work on site. Please don't hesitate to contact TSIB at 1-866-684-WRAP (9727) should you need help completing this form.

Please complete all fields.

1. Contractor Information:

Federal ID # or SS #: 1.1

Company Information (headquarters)		Contact Information	
[Company Name]	1.2	[Name]	1.3
[DBA]			
[Street Address]		[Street Address]	
[City, State, Zip]		[City, State, Zip]	
[Telephone]		[Telephone]	
[Fax]		[Fax]	
[Email Address]		[Email Address]	

Company's Structure 1.4

❑ Corporation ❑ Partnership ❑ S-Corporation
❑ Joint Venture ❑ Sole Proprietor ❑ Other _____

2. Contract Information:

Contract #: 2.1 **#131510-**

Date Contract Awarded: 2.2

Brief Work Description: 2.3

Contract Price: 2.4 $

Is your contract with Turner? 2.5 ❑ Yes ❑ No

Amount of Self Performed Work: 2.6 $

If 'No', identify to whom: 2.7

Start Date on Project: 2.8 ❑ Actual ❑ Estimated

Completion Date: 2.9

3. Contacts:

Position	3.1 Name & Title	3.2 Phone	3.3 Fax	3.4 Email Address
Project Manager				
Insurance				
Payroll				

Provide location of payroll records if different than Company address: 3.5

[Phone]
[Fax]
[Email]

4. Workers' Compensation Insurance Information for Work Done At the Project Site

State a.	Class Code b.	Work Description c.	Man-hours d.	Reportable Payroll e.
4.1				
		Totals	4.2	4.3

5. Provide Your Current Off-Site Workers' Compensation Information

Applicable State	Risk ID Number	Rating Bureau	Anniversary Rating Date	EMR
5.1	5.2	5.3	5.4	5.5

Your Off-Site WC Insurance Carrier's Name: 5.6

Policy No.: 5.7

Effective Date of your Policy: 5.8

Expiration Date of your Policy: 5.9

6. Subcontractor Information: List **all** Subcontractors that will be working for you on this project.

6.1 Subcontractor (FEIN Number)	6.2 Subcontract Amount [$]	6.3 Contact Person and Email Address	6.4 Address	6.5 Phone & Fax	6.6 Estimated Start Date
				P:	
				F:	
				P:	
				F:	
				P:	
				F:	
				P:	
				F:	

7. Project Site Questions

7.1 Will you have any off-site location(s) that are 100% dedicated to this project? ❑ Yes ❑ No If yes, please provide address:

[Address] [City] [State] [Zip]

7.2 Please check if: ❑ Any aircraft used on this project ❑ Any watercraft used on this project

7.3 Provide information regarding labor from either one of the following sources: ❑ Employee leasing firm ❑ Temporary labor agency

[Address]		
[City, State, Zip]		
[Phone]		
[Fax]		
[Email]		

8. WARRANTY INFORMATION

I warrant the following:

1) Enrollment is not automatic and must be confirmed by TSIB as evidenced by a Certificate of Insurance
2) Premiums for this Program are the responsibility of *Turner Construction Company* and I agree that any and all return of premiums, dividends, discounts, or other adjustments to any Program policy(ies) is assigned, transferred and set over absolutely to *Turner Construction Company*. This assignment applies to the Program policy(ies) as now written or as subsequently modified, rewritten or replaced.
3) Rights of Cancellation for all Program insurance policy(ies) arranged by *Turner Construction Company* are assigned to *Turner Construction Company*.
4) I am responsible for premium(s) for all other insurance coverage specified in the Contract Documents with *Turner Construction Company* that are not included in the Turner Construction CCIP Program.
5) I authorize the release of all claim information for all insurance policies under this Program.
6) I recognize it is my responsibility to notify my insurance agent to exclude all work that is done at the project site and covered under the wrap-up program policy(ies).
7) Statements in this application are true and accurate to the best of my knowledge.

9. Signature Requirement:

[Name] _____ [Date] _____

(please print)

[Title] _____ [Signature] _____

You may not be allowed to work on-site until TSIB processes this form.

UNLESS INSTRUCTED OTHERWISE BY TURNER, please email this Form 1 to: WrapUp@tsibinc.com

Every Contractor, Subcontractor or Sub-Tier Contractor must complete this form PRIOR to Project Site mobilization. In addition, you must fill out this form for EVERY contract you are awarded on the Project. All of the information included on this form is required by the Insurance Carrier and Wrap-Up Administrator. A Certificate of Insurance evidencing coverage and a Workers' Compensation policy will be sent to the Enrolled party once the completed form is received by TSIB and processed with the Insurance Carrier. If you need help filing out this information, please contact TSIB at 1-866-684-WRAP (9727).

Section 1: Contractor Information		
1.1		The Federal ID number is your 9 Digit Tax ID number that is valid in all states. If you are a sole proprietor, enter your social security number.
1.2		Name, mailing address and phone/fax number for your company's primary office location.
1.3		Enter the name of the person TSIB should contact if they have any questions. Please include mailing address, phone/fax and email address, if different than 1.2.
1.4		Identify your company's legal structure by checking the box that applies. If the correct legal structure is not specifically listed, please check the "Other" box and specify in the space provided.
Section 2: Contract Information		
2.1		Enter the Contract Number or Purchase Order Number as shown in Turner Construction Company's originating documentation.
2.2		This is the date shown on your Contract with Turner Construction Company
2.3		A brief description of the work you will be performing at the project site.
2.4		The total amount of your contract.
2.5		Check the appropriate box that identifies if you contract directly with Turner Construction Company or are a Subcontractor.
2.6		List the value of amount of work you anticipate will be self-performed. Include both labor and material costs
2.7		If you are a Subcontractor, list the company with whom you have a contract. .
2.8		This is the date you anticipate starting work at the project site and whether the date provided is actual or estimated.
2.9		The date you anticipate completing the work at the project site and whether the date provided is actual or estimated.
Section 3: Contacts		
3.1		Please list the name and title for each function.
3.2		Please list the phone number for each person identified above.
3.3		Please list the fax number for each person identified above.
3.4		Please enter the email address for each person identified above.
3.5		Please list the address where your payroll records are retained. In addition, please list the Address, Telephone, Fax Number and Email Address of the Payroll person listed who is responsible for maintaining the payroll information.
Section 4: Workers' Compensation Information		
4.1	**a**	List the state in which the work will be performed.
	b	The Workers' Compensation class code that applies to the work identified in 2.3. (Most states use a 4 digit number)
	c	Brief Description of work provided by the WC class code provided in 4.1.b.
	d	The estimated Man-hours required to complete the described work by Workers' Compensation class code identified in 4.1.b.
	e	The Estimated Payroll to complete the described work for each Workers' Compensation class code identified in 4.1.b. **Use straight time wage rates only - Do not include premium (excess) overtime wages except in the States of Pennsylvania, Nevada, Utah, Delaware, Ohio and other applicable Workers' Compensation monopolistic States that require the entire unburdened "overtime" payroll to be reported as Reportable Payroll.**
4.2		Total all estimated Man-hours for each class code. Please include information from additional pages if needed.
4.3		Total all estimated **Reportable** Payroll.
Section 5: Current *Off-Site* Workers' Compensation Information *(Information relates to your corporation's existing coverage; identify each modification factor that applies.)*		
5.1		Only the state that the Modification Information applies to.
5.2		**The Bureau File Number is also referred to as your Risk Identification Number. It is used by the insurance carriers to report your loss and payroll information to the rating bureau so they can calculate your experience mod!! Therefore, the claim experience you have on this project will influence your corporate EMR.**
5.3		Bureau Rating Agency. In most states this is NCCI. Please see the note in 5.2
5.4		Your Company's Anniversary Rating Date. Information can be located on your bureau's WC Experience Modification worksheets.
5.5		Enter your current EMR (Experience Modifier Rate). Information can be located on your current Workers' Compensation Declaration Pages.
5.6		Identify your insurance carrier for your OFF-SITE Workers' Compensation Coverage.
5.7		Identify your OFF-SITE Workers' Compensation Policy Number.
5.8		Please indicate the effective date of your Workers' Compensation policy.
5.9		Please indicate the Expiration date of your Workers' Compensation policy.
Section 6: Subcontractor Information *(Provide the following information for each Subcontractor that will be performing work at the project site.*		
6.1		Name of the Subcontracting firm.
6.2		Estimated value of the subcontracted work
6.3		Contact name, preferably the project manager, for the Subcontractor and Email address.
6.4		Mailing address for the Subcontractor.
6.5		Phone and Fax numbers for the Subcontractor.
6.6		Date the Subcontractor is scheduled to begin work on site
Section 7: Enrollment Questions		
7.1		Will you have any off-site locations that will be 100% dedicated to this project? Please include material/supply storage as a possible location. Mark the appropriate box (yes/no). If you answer yes – please provide the address of each location you identified as 100% dedicated.
7.2		Please mark the box or boxes that apply. Contemplate only work performed under this contract.
7.3		Please mark the box or boxes that apply. Employee Leasing Firm are those firms that supply the labor force for your company *(You direct the activities of the Leasing Company's employees*). Temporary Labor Firms supplement your labor force.

If you have questions regarding this form, contact the TSIB Administrator at 1-866-684-WRAP (9727).

Section 9: Signature Requirement: This form must be signed by a representative of your company knowledgeable of its accuracy.

Insurance Cost Worksheet

(Numbers reference attached Instructions)

1. Contractor Information:

Federal ID # or SS #: 1.1

Company Information (headquarters)

[Company Name]	1.2
[DBA]	
[Street Address]	
[City, State, Zip]	
[Telephone]	
[Fax]	
[Email Address]	

Contact Information

[Company Name]	1.3
[Contact Name]	
[Street Address]	
[City, State, Zip]	
[Telephone]	
[Fax]	
[Email Address]	

2. Contract Information

Contract Price: 2.1 $

Amount of Self Performed Work: 2.2 $

Is your contract directly with Turner Construction Company?: 2.3 ❑ Yes ❑ No

If 'No', identify to whom: 2.4

3. Identify your Workers' Compensation Insurance Cost for your Contract:

a State	b Class Code	c Description of Work	d Rate *(per $100 payroll)*	e Man-hours	f Payroll	g WC Premium *((Payroll/100) * Rate)*
3.1						
			Totals:	3.2	3.3	3.4

Employers Liability Rate: 3.5

Employers Liability Premium: 3.6

Subtotal (***3.4 + 3.6***) 3.7

Your Company's Workers' Compensation Experience Modifier: 3.8

Modified Premium (line ***3.7 x 3.8***): 3.9

Claim Retention or Deductible Amount	3.10 Modification & Discount Premium Factors			3.11 Rate (insert N/A if not applicable)	3.12 Amount
$	Mod 1:	**Schedule Credit**	+ or -		
	Mod 2:	**Deductible or Claim Retention Credit**	+ or -		
	Mod 3:	**Healthcare and/or Drug Free Credit**	+ or -		
	Mod 4:	**Assessments**	+ or -		
	Mod 5:		+ or -		
	Mod 6:		+ or -		
	Mod 7:		+ or -		

Total Modification Amount *(Total of all amounts entered in column **3.12**)*: 3.13

Total Workers' Compensation Premium *(line **3.9 +3. 13**)*: 3.14

4. Calculating General Liability Insurance Cost

Rate: 4.1 _____ 4.2 Based On: ❑ Total Payroll **(3.3)** ❑ Contract Price **(2.1)** ❑ Other 4.3 Rate factor: ❑ Per 100 ❑ Per 1,000 4.4 Identify the Amount of Your Claim Retention: _____

GL Premium ***(4.2 × 4.1 ÷ 4.3):*** 4.5

5. Calculating Excess/Umbrella Liability Insurance Cost:

Rate: 5.1 _____ 5.2 Based On: ❑ Total Payroll **(3.3)** ❑ Contract Price **(2.1)** ❑ Other 5.3 Rate factor: ❑ Per 100 ❑ Per 1,000

Premium ***(5.2 × 5.1 ÷ 5.3):*** 5.4

6. Total Cost

Total of all Insurance Premiums ***(Total of lines 3.14 + 4.5 + 5.4):*** 6.1

Overhead & Profit on Insurance Premium %: 6.2 _____

O/H & Profit Amount ***(6.1 x6.2):*** 6.3

Total Initial Insurance Cost *(Total of lines **6.1 + 6.3**):* 6.4

Contractor's Insurance Cost Rate *(**6.4** divided by total payroll in line **3.3** × **100**):* **(Blended Payroll Rate)** 6.5

7. Signature Requirement: I warrant the information presented above and attachments are correct:

Name: _____ (please print) Date: _____

Title: _____ Signature: _____

OTHER REQUIRED DOCUMENTS: In addition to this form, please include the following:

- ☑ Workers' Compensation declaration and rate pages
- ☑ Experience Modification Rate worksheet
- ☑ General Liability declaration and rate pages
- ☑ Umbrella/Excess Liability declaration and rate pages
- ☑ 5 years actual loss experience for each line of coverage in which Contractor retains more than $5,000.

UNLESS INSTRUCTED OTHERWISE BY TURNER, SUBMIT THIS FORM AND THE REQUIRED INSURANCE RATE DOCUMENTS LISTED ABOVE TO:

Turner Surety And Insurance Brokerage, EMAIL: WrapUp@tsibinc.com.

Section 1: Contractor Information		
1.1		The Federal ID number is your 9 Digit Tax ID number that is valid in all states. If you are a sole proprietor, enter your social security number.
1.2		Name, mailing address and phone/fax number for your company's primary office location.
1.3		Please enter the name of the person TSIB should contact if they have any questions. Include the mailing address, phone/fax and email address if different from the primary office location.
Section 2: Contract Information		
2.1		Please identify the total amount of your contract, including both labor and material.
2.2		Identify the amount of work that you anticipate will be self-performed, including both labor and material.
2.3		Check the appropriate box that identifies if you contract directly with Turner Construction Company.
2.4		If you are a Subcontractor, identify the entity with who you are under contract.
Section 3: Identifying your Workers' Compensation Insurance Cost for your Contract:		
3.1	a	Please enter the two-letter abbreviation for the state in which the work will be performed.
	b	Please enter each Workers' Compensation class code that applies to your work identified in 2.1. If you have trouble completing this information, please contact your own insurance agent or broker for help. Attach additional pages if needed.
	d	Please enter your Workers' Compensation rate that applies to the specified class code.
	e	Please enter the estimated Man-hours required to complete the described work for each Workers' Compensation class code.
	f	Please enter the estimated Payroll required to complete your work. Use only unburdened payroll and exclude the premium portion of any overtime pay unless applicable for the Project's location (State dictated).
	g	Calculate the WC Premium by multiplying the Payroll (3.1.f) by the Rate (3.1.d) and dividing the result by 100. Repeat this calculation for each WC class code.
3.2		Total the estimated Man-hours. Be sure to include information from additional pages if used.
3.3		Total the estimated Payroll. Be sure to include information from additional pages if used.
3.4		Total the Workers' Compensation Standard Premium. Be sure to include information from additional pages if used.
3.5		Please enter your Employer's Liability Insurance Rate. This information can be found in your Workers' Compensation policy.
3.6		Calculate your Employer's Liability Premium by multiplying the WC Standard Premium (3.4) by the Employer's Liability Rate (3.5).
3.7		Subtotal: Sum the amounts shown in 3.4 and 3.6.
3.8		Please enter your WC Experience Modifier. This Information can be located on your Workers' Compensation policy or on your NCCI Bureau Rating Sheet.
3.9		Calculate the Modified Premium by multiplying the WC Subtotal (3.7) by the Experience Modifier Rate (3.8).
3.10		Please identify the Modifiers that apply to your Workers' Compensation Premium. This information can be located on your Workers' Compensation Policy. Add additional pages if necessary.
3.11		Please enter the Rate for each identified Modifier. The information can be located on your Workers' Compensation Policy. Insert N/A if not applicable.
3.12		Calculate the Modified Premium Factor Amount by multiplying the Modified Premium (3.9) by the Modified Premium Rate (3.11) and dividing by 100. Be sure to identify if the Modification Factor is an addition or reduction to your premium. Attach additional pages if needed.
3.13		Total the Modified Premium Amounts by adding the numbers in column (3.12). Be sure to include information from additional pages if used.
3.14		Calculate the Total Workers' Compensation Premium by adding the Modified Premium (3.9) and the Premium Modifications (3.13).
Section 4: General Liability Insurance		
4.1		Please enter your General Liability Rate. This number can be found on your General Liability Policy
4.2		Please identify the exposure base your General Liability Rate applies to. If the base is other than Payroll or Revenue, enter the amount and the description in the space provided.
4.3		Please identify the General Liability Rate factor by marking the box.
4.4		Please identify the amount of your Claim Retention if applicable.
4.5		Calculate the General Liability Premium by multiplying the Bases (4.2) by the Rate (4.1) and dividing by the factor (4.3).
Section 5: Umbrella/Excess Liability Insurance		
5.1		Please enter the Excess/Umbrella Liability Rate. This number can be found on your Excess/Umbrella Liability Policy
5.2		Please identify the exposure base the Excess/Umbrella Liability Rate applies to. If the base is other than Payroll or Revenue, enter the amount and description in the space provided.
5.3		Identify the Excess/Umbrella Liability Rate factor by marking the box.
5.4		Calculate your Excess/Umbrella Liability premium my multiplying the Base (5.2) by the rate (5.1) and dividing by the Rate Factor (5.3)
Section 6: Total Cost		
6.1		Calculate the Total of all Insurance Premium by adding Workers' Compensation (3.17), General Liability (4.5), Excess/Umbrella Liability (5.4).
6.2		Please identify the Overhead & Profit Percentage that was applied to this project as part of the Contract Price.
6.3		Calculate the Overhead & Profit Amount by Multiplying the Total of all Insurance Costs (6.1) by the Overhead & Profit Percentage (6.2).
6.4		Calculate the Total Initial Insurance Cost by adding the Overhead & Profit Amount (6.3) with the Total of all Insurance Premium (6.1)
6.5		Calculate your rate by dividing the Total Initial Insurance Cost (6.4) by the Estimated Payroll (3.3) and multiplying by 100.

Section 7: Signature Requirement:
The person signing must be a representative of your company with the authority to verify the information is accurate.

On-Site Payroll Report Information

(Numbers reference attached Instructions)

1. PAYROLL REPORT INFORMATION

Period Beginning:	1.1	**Period Ending:**	1.2	**Year:**	1.3
Contractor:	1.4				
Under Contract with:	1.5				
TSIB Contract # (as identified in previous TSIB correspondence):	1.6 **#131510-**				

2. PAYROLL REPORT ACTIVITY

a State	b Workers' Compensation Class Code	c Work Description	d Man-Hours	e Gross Payroll **	f Reportable Payroll *
2.1					
		TOTALS:	2.2	2.3	2.4

* Use straight time wage rates only - Do not include premium (excess) overtime wages. The States of Pennsylvania, Nevada, Utah, Delaware, Ohio and other applicable Workers' Compensation monopolistic States require the entire unburdened "overtime" payroll to be reported as Reportable Payroll instead of straight overtime.
** Includes overtime paid to employees.

3. SIGNATURE REQUIREMENT: I VERIFY THE INFORMATION PRESENTED ABOVE AND ATTACHMENTS ARE CORRECT:

Name (please print):		**Date:**	
Title:		**Signature:**	

MAKE YOUR JOB EASIER: Information can be submitted on-line at **http://tsibinc.com** **(lower left hand corner, click on "WRAP-UP ADMIN PORTAL")**. Please contact your TSIB Administrator at 1-866-684-WRAP (9727) to obtain a User ID and Password.

NOTES:

1) **YOU MUST COMPLETE A SEPARATE REPORT FORM FOR EACH CONTRACT AWARDED ON THE PROJECT**
2) **A MONTHLY PAYROLL REPORT MUST BE SUBMITTED FOR EACH MONTH INCLUDING "ZERO DOLLAR ($0.00) PAYROLL", IF APPLICABLE, UNTIL COMPLETION OF THE WORK UNDER EACH CONTRACT.**
3) **ALL PAYROLLS MUST BE SUBMITTED NO LATER THAN THE 10TH OF THE MONTH FOLLOWING THE WORK PERFORMED**

Email to: **Turner Surety And Insurance Brokerage**

Email: **WrapUp@tsibinc.com**

Contractor Portal: **http://tsibinc.com (lower left hand corner, click on "WRAP-UP ADMIN PORTAL")**

Please report all payroll directly online at the web address at the bottom of the page.

Section 1: Report Identification	
1.1	This is the first day of the period you are reporting on.
1.2	This is the last day of the period you are reporting on.
1.3	The current year.
1.4	The name of your company.
1.5	If you are a Subcontractor, identify the name of the company you are contracted to. If you are a Prime Contractor enter N/A
1.6	Provide your TSIB Contract Number (as identified in previous correspondence from TSIB).

Section 2. Activity Report		
2.1		Provide the following information for each Workers' Compensation Class Code that applies to work performed during the reporting period:
	a	This is the state in which the work was performed.
	b	Workers' Compensation Class Code. (Most states use a four digit number).
	c	Description of the work by class code.
	d	List the Man-hours worked by your employees for each applicable class code.
	e	This is the Gross Payroll paid to your employees. This should include the unburdened overtime pay.
	f	Determine the Reportable Payroll. Reportable Payroll does not include the premium portion of any overtime pay (i.e. 45 hours X $10.00/hr = 450.00 *do not include the premium overtime pay of $5.00/hour for the 5 hours of overtime*). **The States of Pennsylvania, Nevada, Utah, Delaware and applicable Workers' Compensation monopolistic States require the entire unburdened "overtime" payroll to be reported as Reportable Payroll. If you are unsure whether to include the unburdened overtime portion as Reportable Payroll, consult with the Project's State Workers' Compensation Bureau for clarification.**
2.2		Total the Man-hours provided on the payroll report.
2.3		Total the Gross Payroll provided.
2.4		Total the Reportable Payroll.

Section 3. Signature Requirement: Must be signed by a representative of your company with the authority to verify the information is correct.

MAKE YOUR JOB EASIER: Information can be submitted on-line at **http://tsibinc.com** **(lower left hand corner, click on "WRAP-UP ADMIN PORTAL")**. Please also contact your TSIB Administrator to obtain a user ID and Password at 1-866-684-WRAP (9727).

Work Completion Form

(Numbers reference attached Instructions)

1. Contractor and Date Information

Contractor Name:	1.1	
TSIB Contract # (as identified in previous TSIB correspondence):	1.2	**#131510-**
Describe the Work Performed on Project:	1.3	
Date when Work Completed	1.4	

2. Subcontractor Information and Payroll Records Location

List all of your Subcontractors that have completed their Work at the Project Site:
(Include attachment if more space is needed)

a Subcontractor's Name	b Contract Number	c Description of Work Performed	d Date Work Completed
2.1			

Receipt of this form by the TSIB Wrap-Up Service Center will start the payroll Audit Process so please list the location of your payroll records:

Address:	2.2
City, State, Zip Code:	
Contact Name and Phone #:	

3. Signature Requirement:

*****PLEASE NOTE THAT THIS FORM CAN NOT BE VERIFIED UNLESS YOUR PARENT CONTRACTOR HAS SIGNED AS WELL.**

The Company representative signing this form below requests termination of coverage under the CCIP as of the date indicated above for the specified Contract listed. Should we return to the work Site, we will be working under our own insurance program and must provide *your Parent Contractor* with a Certificate of Insurance showing our own coverage as detailed in our contract.

SIGNED (SUB): 3.1

Name & Title Date

APPROVED: 3.2

Parent Contractor Verification Signature (Name & Title) Date

PLEASE SUBMIT THIS SIGNED FORM TO TURNER AT THE JOBSITE OFFICE. TURNER WILL EXECUTE AND FORWARD TO:

Email to: **Turner Surety And Insurance Brokerage Wrap-up Service**

Email: **WrapUp@tsibinc.com**

This form should be completed whenever work is completed for each Contract or Subcontract. Note that this Form will request termination of CCIP coverage and indicate to the insurance company that they can begin their final audit of payrolls for each Contractor and Subcontractor identified in Sections 1 and 2**.** **PLEASE NOTE THAT THIS FORM CAN NOT BE FINALIZED UNLESS YOUR PARENT CONTRACTOR HAS SIGNED AS WELL.** Final payments and release of any Retainage may not happen until all payroll work is complete and finalized and will have to be reviewed with the Turner Project Manager.

Section 1: Contractor and Date Information		
1.1		The name of the contractor completing their work.
1.2		The TSIB Contract Number for the work being completed. Your TSIB Contract Number is identified in previous correspondence from TSIB.
1.3		A short description of the work being completed.
1.4		The date the work was completed.
Section 2: Subcontractor Information and Payroll Records Location		
2.1	a	Please enter the name of <u>each and every</u> Subcontractor that performed work for you that has also completed their work. Please note, for this form to be accurate and compliant, all subcontractors must be complete with their work!!
	b	Please enter Subcontractor's TSIB Contract Number.
	c	Please provide a brief description of each Subcontractor's work.
	d	Please provide the Date the Subcontractor completed their work.
2.2		Please identify the physical location where your payroll records are retained. Provide the Address, City, State, Zip Code, Contact Name and Telephone Number of the person responsible for maintaining the payroll information for audit purposes. This will help the Insurance Company complete their physical audit. <u>Please note that the requirement to perform a physical audit is at the discretion of the Insurance Company. If you have any concerns about the procedures they use to complete the audit, please do not hesitate to contact TSIB at 1-866-684-WRAP (9727)</u>
Section 3: Signature Requirement:		
3.1		This form has to be signed by a representative of your company with the authority to verify that the information contained in the form is accurate.
3.2		Make sure this form is also signed by your Parent Contractor or the Turner Project Manager or Turner Superintendent. Your Parent Contractor, the Turner Project Manager or Superintendent is required to forward the completed form to TSIB at WrapUp@tsibinc.com.

EXHIBIT 1 – SAMPLE ENROLLED PARTY Subcontractor Certificate of Insurance

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:	
Insurance Agency's/Brokerage's Name And Address	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	PRODUCER CUSTOMER ID #:	

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
Subcontractor's Name and Address Sample Certificate for Enrolled Parties Required Insurance	INSURER A:	
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	

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.

INS LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [X] PROJECT LOC			Policy Number			EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	*Limits as stipulated in Turner's contract with the Prime Sub, or as otherwise instructed by Turner. If no indication is given, then the minimum required limits are $5,000,000*
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			Policy Number			COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per Accident)	*$1,000,000 (Except in the State of New York - $2,000,000)*
	UMBRELLA LIAB OCCUR **EXCESS LIAB** CLAIMS-MADE DEDUCTIBLE RETENTION **$**			Policy Number			EACH OCCURRENCE AGGREGATE	*Limits as stipulated in Turner's contract with the Prime Sub, or as otherwise instructed by Turner. If no indication is given, then the minimum required limit is $5 million ($10 million in New York State)*
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		Policy Number			[X] WC STATU-TORY LIMITS [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 **$1.000,000** **$1.000,000** **$1.000,000**
	OTHER: EQUIPMENT FLOATER			Policy Number			Limit equal to Full Coverage of Subcontractor's owned or rented machinery, equipment, tools, & temporary structures not designed to become a permanent part of the Work	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach Additional Remarks Schedule if more space is required): RE: Work performed at the Turner Construction **#131510- Great Wolf Lodge - Garden Grove.** Certificate Holders are Additional Insureds on a Primary and Non-contributing basis on the General Liability (ISO endorsement CG 20 10 11 85 or its equivalent), Automobile and Excess/Umbrella Liability Policies. Waiver of Subrogation in favor of Certificate Holders applies to all policies. **GL and WC coverage apply off-site.**

CERTIFICATE HOLDER

GWGG, LLC, GGMXDR, Inc.; McWhinney Real Estate Gervices, Inc.; David L. Bray, Great Wolf Resourts, Inc., City of Garden Grove as Successor Agency to the Garden Grove Agency for Community Development, City of Garden Grove, and their respective officers, employees, representatives, and agents. The Turner Corporation, Turner Construction Company, their officials, employees and agents and any wholly owned Subsidiaries or parent organizations, and all Enrolled Parties.
c/o Turner Surety And Insurance Brokerage
440 Wheelers Farms Road
Milford, CT 06461
Attention: David McClure

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

ACORD 25 (2009/09)

EXHIBIT 2 – SAMPLE EXCLUDED PARTY and PARTIES NO LONGER COVERED BY THE CCIP Certificate of Insurance

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:	
Insurance Agency's/Brokerage's Name And Address	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	PRODUCER CUSTOMER ID #:	

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
Subcontractor's Name and Address Sample Certificate for Excluded Parties and Parties No Longer Covered by the CCIP Required Insurance	INSURER A:	
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	

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.

INS LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [X] PROJECT LOC			Policy Number			EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	*Limits as stipulated in Turner's contract with the Prime Sub, or as otherwise instructed by Turner. If no indication is given, then the minimum required limits are $5,000,000*
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS			Policy Number			COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per Accident)	*$1,000,000 (Except in the State of New York - $2,000,000)*
	UMBRELLA LIAB OCCUR **EXCESS LIAB** CLAIMS-MADE DEDUCTIBLE RETENTION **$**			Policy Number			EACH OCCURRENCE AGGREGATE	*Limits as stipulated in Turner's contract with the Prime Sub, or as otherwise instructed by Turner. If no indication is given, then the minimum required limit is $5 million ($10 million in New York State)*
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	**Y/N** [N] **N / A**		Policy Number			[X] WC STATU-TORY LIMITS [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	**$1.000,000** **$1.000,000** **$1.000,000**
	OTHER: EQUIPMENT FLOATER			Policy Number			Limit equal to Full Coverage of Subcontractor's owned or rented machinery, equipment, tools, & temporary structures not designed to become a permanent part of the Work	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach Additional Remarks Schedule if more space is required): RE: Work performed at the Turner Construction **#131510- Great Wolf Lodge - Garden Grove.** Certificate Holders are Additional Insureds on a Primary and Non-contributing basis on the General Liability (ISO endorsement CG 20 10 11 85 or its equivalent – copy attached), Automobile and Excess/Umbrella Liability Policies. Waiver of Subrogation in favor of Certificate Holders applies to all policies**. ALL COVERAGES LISTED APPLY ON-SITE FOR ALL OPERATIONS OF THE INSURED.**

CERTIFICATE HOLDER

GWGG, LLC, GGMXDR, Inc.; McWhinney Real Estate Gervices, Inc.; David L. Bray, Great Wolf Resourts, Inc., City of Garden Grove as Successor Agency to the Garden Grove Agency for Community Development, City of Garden Grove, and their respective officers, employees, representatives, and agents. The Turner Corporation, Turner Construction Company, their officials, employees and agents and any wholly owned Subsidiaries or parent organizations, and all Enrolled Parties.
c/o Turner Surety And Insurance Brokerage
440 Wheelers Farms Road
Milford, CT 06461
Attention: David McClure

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

ACORD 25 (2009/09)

GENERAL LIABILITY CONTRACTOR CONTROLLED INSURANCE PROGRAM CLAIM REPORT FORM

Please complete this form and return it to the Project Site Safety Coordinator no longer than 24 hours after the incident.

Date of Accident	Time

POLICYHOLDER

Insured Name	Location Code	Insured Phone

Insured Address, City, State, Zip

Mailing Address, City, State, Zip (If Different)

DESCRIPTION OF ACCIDENT

Address Where Accident Occurred (Street, City, State, Zip)

Exact Location of Accident (i.e.: AISLE 1, PRODUCE DEPT.)

Accident Description (be as specific as possible)

Was there a 3rd Party Involved? Yes ☐ No ☐	Name of 3rd Party(s) & Contact Information

WITNESSES

Witness Name	Address, City, State, Zip	Phone
Witness Name	Address, City, State, Zip	Phone
Witness Name	Address, City, State, Zip	Phone

PROPERTY DAMAGE

Name of Owner	Home Phone	Business Phone

Address, City, State, Zip

Type of Property and Extent of Damage

PERSONAL INJURY

INJURED PARTY 1			INJURED PART 2		
Name of Person Injured		Sex	Name of Person Injured		Sex
Name of Parent or Guardian of Under 18 Yrs.			Name of Parent or Guardian of Under 18 Yrs.		
Address, City, State, Zip			Address, City, State, Zip		
Home Phone		Business Phone	Home Phone		Business Phone
D.O.B.	Age	Social Security Number	D.O.B.	Age	Social Security Number
Description of Injuries			Description of Injuries		
Medical Treatment (i.e.: Hospital/Clinic Name, Address, Phone			Medical Treatment (i.e.: Hospital/Clinic Name, Address, Phone		

ADDITIONAL COMMENTS

ASC-3094 R1

WORKERS' COMPENSATION CONTRACTOR CONTROLLED INSURANCE PROGRAM CLAIM REPORT FORM

Please complete this form and return it to the project site safety coordinator no longer than 24 hours after the incident.

ACCOUNT INFORMATION

PROJECT NAME/ExPRS Call ACCOUNT NAME:

Contractor Name:

CLAIM INFORMATION

Date/Time of Injury: am pm | After the call, write claim number here: **WC**

Is this claim work related? Yes ☐ No ☐ | Will the employee miss time from work? Yes ☐ No ☐

EMPLOYEE INFORMATION

Employee's Social Security Number: | Employee's Name:

Home Address: (Street) (City) (State) (Zip)

Home Phone Number: | Male ☐ Female ☐

Date of Birth: | Marital Status: (check one) Single ☐ Married ☐ Widowed ☐ Divorced ☐

Hire Date: | Number of Dependents: Dependents Under 18:

Occupation: | Department Name:

State Hired: | Supervisor Name & Phone:

Current Weekly Wage: | Hourly Wage: | Hours Worked Per Week:

Days Worked Per Week: | Hours Worked Per Day: | Employment Status:

Employer Report No.: | Employee SS No.: | Was Salary Continued:

Was Employee Paid in Full for Date of Injury: | How often is employee paid:

Education Level: | Any Prior WC Injuries: | OSHA Reference No.:

EMPLOYER INFORMATION

Contact Name, Telephone Number, and Title:

PROJECT/WORK LOCATION: (Street) (City) (State) (Zip)

Mailing Address: (City) (State) (Zip)

Employer Location Code: | Employer SIC:

Employer FED ID: | Employer Code:

Nature of Business

Policy Number:

ACCIDENT INFORMATION

Did the Accident Occur at the Work/Project Location? Yes ☐ No ☐ If not, where?

Accident Address: (Street) (City) (State) (Zip)

Nature of Accident:

Give a Full Description of the Accident: (Be As Complete As Possible)

Are Other WC Claims Involved? Yes ☐ No ☐ | Date and Time Reported to Employer: am pm

Person Reported To:

INJURY INFORMATION

Injury Description:

Date of Death (*If applicable*):	Is Employee Hospitalized? Yes ☐ No ☐
Lost Time? Yes ☐ No ☐	If Yes, What was First Full Day Out:
Date Last Day Worked:	Date Disability Began:
Date Returned to Work:	**OR** Estimated Return to Work Date:

Time Workday Began: am pm

Was worker placed on Restricted Duty?	What restrictions? For how long?
Which Part of the Body Was Injured: (e.g. Head, Neck, Arm, Leg)	Nature of Injury: (e.g. Laceration, Bruise, Fracture)
Part of Body Location: (e.g. Left, Right, Upper, Lower)	Source of Injury:

Was worker placed on restricted duty? What restriction? How long (# days)?

MEDICAL INFORMATION

Safeguards Provided? Yes ☐ No ☐	Safeguards Utilized? Yes ☐ No ☐

Initial Medical Treatment: Circle One ER Treated and Released Hospitalized Physician/Clinic Minor/Onsite No Medical Treatment

Hospital - Name, Address, Phone, Fax:

Clinic/Doctor - Name, Address, Phone, Fax, Specialty:

WITNESS INFORMATION

Were There Any Witnesses? Yes ☐ No ☐

If Yes, List Names and How to Contact Them:

ADDITIONAL COMMENTS & INFORMATION

REPORT PREPARED BY

Name: Title:

Signature: Phone:

ASC-3088 R2

WC Form 1 – Turner's 90 Day Modified Alternate Duty Program

RETURN TO WORK PROGRAM – Turner Construction Company CCIP

Purpose:

TURNER Construction Company is committed to providing a safe work place for both its employees and the subcontractors' employees; facilitating prompt quality medical care in the event of a work related injury; and pursuing modified alternate duty to minimize the risks and financial burdens to its workforce.

TURNER Construction Company has established a return to work (RTW) program which is expected to be implemented by each subcontractor. Each subcontractor will provide a 90 day Modified Alternate Duty Program for an employee who has sustained a work related injury or illness and is medically unable to perform all or any part of his / her normal duties during all or any part of the normal workday or shift.

This applies to all Contractors on the project. The policy must include, but not be limited to:

1) All work related injuries will be reported to your supervisor and TURNER Construction Company immediately.
2) All injured employees will be provided with an approved medical treatment facility listing where appropriate, or a recommended panel listing. If there is any doubt as to where to go for treatment, the injured employee must contact TURNER Construction Company.
3) Contractors need to communicate to the injured employee and treating physician TURNER Construction Company's 90 Day Modified Alternate Duty Program and facilitate Modified Alternate Duty with the treating physician and the employee.
4) Modified Alternate Duty assignments must comply with all medical limitations outlined by the treating physician so that injury or aggravation does not occur.
5) Project Managers, Supervisors and Foreman all must be informed of the modified alternate duty assignment, length of alternate duty, and the restrictions and responsible for the adherence.
6) Failure of a Contractor to provide reasonable Modified Alternate Duty to an injured worker will result in a $1500 weekly assessment against the Contractor until the injured employee is returned to work in either a modified alternate duty position or full duty.
7) The injured employee must provide the Project Managers, Supervisors and Foreman copies of all return to work notes, either modified duty or full duty.
8) The injured employee is not to assume normal work activities unless they have presented medical documentation releasing them to their normal duties to TURNER.
9) No injured employee on modified alternate duty will be allowed to work more than forty (40) hours per week or holidays.
10) The injured employee will remain on the project where the injury occurred while on Modified Alternate Duty or be transferred to another Project if the current Project's work phase is completed.

Responsibilities:

The following will define the reporting responsibilities of each party involved in the CCIP or Corporate Program for Return to Work.

Injured Employee – A successful return to work program requires the cooperation and accountability of all your employees.

1) Ensure that your employees have attended training sessions and clarify any procedures which are unclear.
2) They are to report all injuries, even minor incidents, immediately within established reporting protocols.
3) They are to work closely with managers / supervisors and communicate all necessary information regarding their ability to return to work.
4) They are to provide the treating physician with the information necessary to help them determine how and when they can return to work.
5) They are to work within their medical stated limitations as outlined by their treating physician.
6) They are to help co-workers stay focused and provide a positive environment when they return to modified alternate duty.

Supervisor / Manager – Supervisors / Managers play a key role in the success of the return to work program. They must be willing to implement and manage the program.

1) Understand and support TURNER'S written policies / procedures and maintain a listing of Position Descriptions as outlined by TURNER.
2) Facilitate treatment procedures with injured employee and ensure that they have received a copy of the Medical Information Claim Folder.
3) Complete the Accident Investigation Form immediately after the incident and send to TURNER.
4) Coordinate Modified Alternate Duty with the injured employee and TURNER once you are aware and have received medical documentation outlining the injured employee's work abilities.
5) Monitor the injured employee's progress on modified alternate duty and provide weekly updates to the TURNER Claim Coordinator.

TURNER Claim Coordinator – The Claim Coordinator is the major communication link between the employee, the supervisor, the site safety personnel, the medical provider and Liberty Mutual.

1) Understand and promote the return to work program.
2) Field and answer questions regarding the Return to Work Program.
3) Ensure that all injuries / incidents are reported promptly to Liberty Mutual.
4) Follow up for medical documentation regarding work abilities and facilitate return to work in the modified alternate duty program where appropriate.
5) Maintain communication with the injured worker, treating physician and supervisor to ensure that the injured worker is working within their medical abilities.
6) Evaluate the modified alternate duty at a maximum of 30 day intervals.
7) Record and report progress and concerns to management at least quarterly.

Liberty Mutual Team – Are responsible for the daily claim handling guidelines outlined in their SSI.

1) Coordinate medical care and return to work issues.
2) Contact and communicate with the treating physician on an ongoing basis.
3) Manage issues related to claim file resolution.
4) Analyze losses and recommend corrective action.

Work Flow for Turner's Modified Alternate Duty Program

The following charts outline the workflow guidelines for each anticipated return to work scenario and define the expectations of each involved party. It is imperative that all injured workers receive proper medical treatment and that they are not returned to work without proper medical documentation releasing them to either modified duty or full duty.

NO LOST TIME w/ ONE TIME OFFICE VISIT

Employee	Sustains Incident and reports immediately to their Supervisor
Supervisor	Supervisor reports Incident to Site Safety / Field Supervisor immediately
Site Safety / Field Supervisor	Upon Incident notification, gives Employee Medical Information Claim Folder and facilitates medical treatment where appropriate. Calls in Incident to Liberty 800 reporting number. **CCIP 1-877 4-TURNER**
Employee	Seeks immediate medical treatment where appropriate. Gives the treating physician the Medical Information Claim Folder. Receives from the treating physician a return to work note indicating full duty. Immediately provides the Site Safety / Field Supervisor a copy of the medical note.
Site Safety / Field Supervisor	Immediately faxes medical note to Claim Coordinator and Liberty Mutual. Verifies with Supervisor that Employee has actually returned to job site. Once verified, immediately provides information to Claim Coordinator.
Employee	Returns to work full duty.
Claim Coordinator	Advises Liberty Mutual of RTW status of Employee. Faxes all medical notes and documentation to Liberty Mutual upon receipt.
Liberty Mutual	Creates claim file upon receipt of 800 report. Completes claim handling protocols as outlined in Special Service Instructions.

NO LOST TIME w/ ON GOING TREATMENT

Employee	Sustains Incident and reports immediately to their Supervisor
Supervisor	Supervisor reports Incident to Site Safety / Field Supervisor immediately
Turner Site Safety / Superintendent	Upon Incident notification, gives Employee Medical Information Claim Folder and facilitates medical treatment where appropriate. Calls in Incident to Liberty 800 reporting number. CCIP **1-877-4-TURNER**
Employee	Seeks immediate medical treatment where appropriate. Gives the treating physician the Medical Information Claim Folder. Receives from the treating physician a return to work note indicating full duty. Immediately provides the Site Safety / Field Supervisor a copy of the medical note.
Turner Site Safety / Superintendent	Immediately faxes medical note to Claim Coordinator and Liberty Mutual. Verifies with Supervisor that Employee has actually returned to job site. Once verified, immediately provides information to Claim Coordinator.
Employee	Returns to work full duty.
Claim Coordinator	Advises Liberty Mutual of RTW status of Employee. Faxes all medical notes and documentation to Liberty Mutual upon receipt.
Liberty Mutual	Creates claim file upon receipt of 800 report. Completes claim handling protocols as outlined in Special Service Instructions.
Employee	Follows up with medical treatment as outlined by treating physician. At the end of each office visit, provides the Site Safety / Field Supervisor with a copy of the doctor's note regarding RTW and further treatment.
Turner Site Safety / Superintendent	Immediately faxes all medical notes to Claim Coordinator and Liberty Mutual. Verifies with Supervisor that Employee is still working. Continues to provide information to Claim Coordinator upon verification of RTW.
Claim Coordinator	Faxes all medical notes and documentation to Liberty Mutual upon receipt. Monitors RTW status of Employee.
Liberty Mutual	Continues to follow up with treating physician to monitor medical treatment and RTW status.

RELEASED TO MODIFIED ALTERNATE DUTY w/ CONTINUED TREATMENT

Employee	Sustains Incident and reports immediately to their Supervisor
Supervisor	Supervisor reports Incident to Site Safety / Superintendent immediately
Turner Site Safety / Superintendent	Upon Incident notification, gives Employee Medical Information Claim Folder and facilitates medical treatment where appropriate. Calls in Incident to Liberty 800 reporting number. CCIP 1-877-4-TURNER
Employee	Seeks immediate medical treatment where appropriate. Gives the treating physician the Medical Information Claim Folder. Receives from the treating physician a return to work note indicating work restrictions. Immediately provides the Site Safety / Field Supervisor a copy of the medical note noting work restrictions.
Site Safety / Field Supervisor	Immediately faxes medical note to Claim Coordinator and Liberty Mutual. Coordinates with Supervisor and Claim Coordinator Modified Alternate Duty for Employee. Once modified duty outlined, immediately provides information to Claim Coordinator.
Employee	Returns to work modified alternate duty.
Claim Coordinator	Advises Liberty Mutual of RTW status of Employee. Faxes all medical notes and documentation to Liberty Mutual upon receipt.
Liberty Mutual	Creates claim file upon receipt of 800 report.

	Completes claim handling protocols as outlined in Special Service Instructions. Liberty immediately sends written verification via Certified Mail to Employee and a copy to Claim Coordinator of Modified Alternate Duty provided by Site once contacted by Site verifying modified duty provided.
Employee	Follows up with medical treatment as outlined by treating physician. At the end of each office visit, provides the Site Safety / Field Supervisor with a copy of the doctor's note regarding RTW and further treatment.
Turner Site Safety / Superintendent	Immediately faxes all medical notes to Claim Coordinator and Liberty Mutual. Verifies with Supervisor that Employee is still working with medical work abilities. Continues to provide information to Claim Coordinator upon verification of RTW.
Claim Coordinator	Faxes all medical notes and documentation to Liberty Mutual upon receipt. Monitors RTW status of Employee.
Liberty Mutual	Continues to follow up with treating physician within 24 hours of each office visit to monitor medical treatment / discharge and facilitate full duty return to work.
Employee	Is released to RTW full duty. Immediately provides Site Safety / Field Supervisor with a copy of the full duty RTW note. Returns to work full duty.
Turner Site Safety / Superintendent	Immediately faxes medical note to Claim Coordinator and Liberty Mutual. Verifies with Supervisor that Employee has actually returned to work full duty. Once verified, immediately provides information to Claim Coordinator.
Claim Coordinator	Faxes all medical notes and documentation to Liberty Mutual upon receipt. Verifies full duty RTW status of Employee.
Liberty Mutual	Continues to follow up with treating physician within 24 hours of each office visit to monitor medical treatment / discharge and verify full duty return to work.

Note to Claim Coordinator: Notify Liberty Mutual Claim Department when an employee returns to work and if they fail to return when released by the treating doctor. The employee's Modified Alternate Duty will end when:

1) released to regular work
2) employee returns in another capacity
3) employee has exceeded 90 day program for modified alternate duty
4) employee quits or is terminated for reasons unrelated to the injury
5) worker's compensation claim is closed
6) company withdraws the modified duty assignment

Note to Supervisors – You are to keep track of all modified alternate duty activity and report the progress of each injured employee weekly to the Claim Coordinator. You shall also provide copies of all medical releases, agreements, notes, etc to the Claim Coordinator and keep a copy to maintain accurate records for the OSHA 300 log. Failure to provide appropriate modified alternate duty will result in a penalty assessment of $1500 weekly for each week the injured employee has not returned to work.

OUT OF WORK w/ ON GOING TREATMENT

Employee	Sustains Incident and reports immediately to their Supervisor
Supervisor	Supervisor reports Incident to Site Safety / Field Supervisor immediately
Turner Site Safety / Superintendent	Upon Incident notification, gives Employee Medical Information Claim Folder and facilitates medical treatment where appropriate. Calls in Incident to Liberty 800 reporting number. CCIP 1-877 4-TURNER; Corporate 1-877 4-TURNER
Employee	Seeks immediate medical treatment where appropriate. Gives the treating physician the Medical Information Claim Folder. Receives from the treating physician indicating out of work. Immediately provides the Site Safety / Field Supervisor a copy of the medical note noting out of work.
Turner Site Safety / Superintendent	Immediately faxes medical note to Claim Coordinator and Liberty Mutual. Discusses Modified Alternate Duty program with Employee and Supervisor.
Employee	Returns home to follow treatment protocols.
Claim Coordinator	Advises Liberty Mutual of RTW or Out Of Work status of Employee. Faxes all medical notes and documentation to Liberty Mutual upon receipt.
Liberty Mutual	Creates claim file upon receipt of 800 report. Completes claim handling protocols as outlined in Special Service Instructions. Liberty immediately follows up with treating physician to discuss Modified Alternate Duty Program and verify work abilities using approved Physical Capabilities Form and verifying that treating physician has copy of Employee's Position Description.
Employee	Follows up with medical treatment as outlined by treating physician. At the end of each office visit, provides the Site Safety / Field Supervisor with a copy of the doctor's note regarding RTW and further treatment. Maintains weekly contact with Supervisor and Claim Coordinator regarding treatment and expected RTW.
Turner Site Safety / Superintendent	Immediately faxes all medical notes to Claim Coordinator and Liberty Mutual. Continues to provide information to Claim Coordinator upon verification of RTW.
Claim Coordinator	Faxes all medical notes and documentation to Liberty Mutual upon receipt. Monitors RTW status of Employee. Maintains weekly contact with Employee. Discusses Modified Alternate Duty options w/ Liberty Mutual on Weekly basis.
Liberty Mutual	Continues to follow up with treating physician within 24 hours of each office visit to monitor medical treatment / discharge and facilitate full duty / modified duty return to work.
Employee	Is released to modified duty. See Modified Alternate Duty Table.
Turner Site Safety / Superintendent	See Modified Alternate Duty Table.
Claim Coordinator	See Modified Alternate Duty Table.
Liberty Mutual	Liberty immediately sends written verification via Certified Mail to Employee and a copy to the Claim Coordinator of Modified Alternate Duty provided by Site once contacted by Site verifying modified duty provided. Continues to follow up with treating physician within 24 hours of each office visit to monitor medical treatment / discharge and verify full duty return to work. See Modified Alternate Duty Table.

Note to all Parties – Lost time ends when the injured employee is returned to their pre-injury position or when / if the injured employee refuses appropriate work offered consistent with the medical work abilities

Turner Safety / Superintendent:
Fax this Form to Claims Coordinator

TURNER CONSTRUCTION

Fax Number:
Site Phone:
PHYSICIAN:

NOTE TO TREATING

1. **Please fax this to the number listed above upon completion.**
2. **A copy must be given to the injured employee to return to the job site.**

Doctor's Initial Report Form

Completed by Site:
Injured Associate:
_____
Associate
Address:_____
Telephone Number: _____ Date of Injury:
_____
Job Title: _____ SSN / DOB:
_____
Accident Description (include Body Part, Nature, Cause, etc):_____
_____
___
Authorized By: _____ Title:
_____

Note: If this medical condition is classified non-work related, the above individual shall be referred to his / her own personal physician for further evaluation.
AUTHORIZATION FOR CONTINUED TREATMENT MUST BE OBTAINED BY DIALING

☐ Worker's Compensation ☒ Modified Alternate Duty Available ☐ Urine Drug Screen ☐ Breathalyzer Test

TO BE COMPLETED BY PHYSICIAN

Physician Data (Name, Address, Phone, etc):

_____
_____

Diagnosis:_____

Accident History:

_____

Mechanism of Injury:_____

Exam Findings / Treatment Recommendations:_____
_____

_____**Return to Full Duty**		**Date:**_____	**RTO:**_____
_____**Out of Work**	**From:**_____	**To:**_____	**RTO:**_____
_____**Return to Work w/ Specific Restrictions**		**Date:**_____	**RTO:**_____

Please see SPECIFIC RESTRICTIONS **below –** NOTE – TURNER CONSTRUCTION HAS AN ACTIVE MODIFIED DUTY PROGRAM

SPECIFIC WORK RESTRICTIONS: EST. LENGTH OF MODIFIED DUTY: _____ days / weeks

_____Sedentary Work Only
_____No Operating of Heavy Equipment
_____No Work Requiring Continuous Walking and/or Standing for ___1hr ___2hrs ___3hrs ___4hrs ___5hrs+
_____No Work Requiring Repetitive or Continuous Bending or Stooping for ___1hr ___2hrs ___3hrs ___4hrs ___5hrs+
_____No Lifting Over _____lbs
_____No Carrying / Pushing / Pulling Over _____lbs
_____No Work Requiring Use of Arms above Shoulder Level
_____Additional Restrictions:

_____ _____
Physician Signature **Date**

WC Form 3 – Position Description

TURNER CONSTRUCTION JOB ANALYSIS

JOB TRADE/CRAFT:

Task Description/Primary or Daily Duties:

I. Working Conditions:

II. Specific Equipment Operations or Specific Safety Devices or Other Relevant Factors:

III. Physical Demands

Task	Continuous	Intermittent	Seldom
Standing			
Walking			
Combined Standing/Walking			
Sitting			
Lifting/Lowering/Carrying – Weights			
under 25 lbs			
25-50 lbs			
Over 50 lbs			
Lifting/Lowering/Carrying - Ranges			
Floor to Knuckle			
Knuckle to Shoulder			
Shoulder and above			
Bending			
Twisting			
Reaching			
Pushing/Pulling			
Crouching/Stooping			
Kneeling			
Climbing			
Operating Arm Controls or Leg Controls			
Upper Body-Shoulder/Elbow Use			
Hand/Wrist Flexion-Extension			
Noise/Dust/Chemical Exposures			
Confined Space Hazards			
Working at Heights			
Operating Mobile Equipment/Machinery			

Turner Construction
<address>
<address>
Attn: <Safety Manager>

Injured Worker: _____
Date of Injury: _____
Subcontractor: _____
Job Site: _____

Medical Authorization Form

I, _____ (injured worker), hereby authorize _____ (name of doctor) and any other provider of medical, dental, or hospital services to give to Turner Construction & Liberty Mutual, hereinafter called the company, any medical, dental or hospital records which have been acquired in the course of any examination of or treatment to _____ (injured worker), for a workers' compensation injury or disease commencing on or about_____ (date), including any medical history relating thereto.

This information is to be used in the evaluation by the company, its agents, employees, or any other person performing a business, professional, or insurance function for their benefit of a workers' compensation claim presented to the company and will not be given, sold, transferred, or in any way relayed to another person without further written authorization, except as required by law. This information may, however, be redisclosed to persons or organizations engaged in the prevention, detection or prosecution of fraud or other illegal activities.

This authorization shall be valid for the duration of the subject claim. I know I may request a copy of this authorization. A photographic copy of this authorization shall be as valid as the original.

Signature_____ Date _____