

# ALLIANCE OF SCHOOLS FOR COOPERATIVE INSURANCE PROGRAMS (ASCIP) OWNER-CONTROLLED INSURANCE PROGRAM (OCIP)

## Project Manual

Project:

Site Code:

Project Address:

Arthur J. Gallagher Risk Management Services, Inc.  
Arthur J. Gallagher & Co., Insurance Brokers of California, Inc.  
18201 Von Karman Avenue | Suite 200  
Irvine, CA 92612  
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**Gallagher**

Insurance | Risk Management | Consulting

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**PREPARED BY:**

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## I. Introduction

The District has implemented an Owner Controlled Insurance Program (OCIP) for the construction of this project. This manual was prepared by Arthur J. Gallagher & Co., who is the insurance broker and OCIP administrator for this project. The manual is designed to identify, define and assign responsibilities for the administration of the OCIP.

### WHAT THIS MANUAL DOES:

- Generally describes the OCIP
- Identifies responsibilities of the various parties involved in the OCIP
- Describes some audit and administrative procedures
- Provides answers to basic questions about the OCIP

### WHAT THIS MANUAL DOES NOT DO:

- Provide coverage interpretations. The actual terms and conditions of the OCIP policy will determine coverage.
- Provide complete information about coverages
- Provide answers to specific claims questions.

Certain insurance coverages are being provided for the term of your contract at no cost to you. These manual details the coverages provided the steps necessary to enroll, and the procedures in the event of a claim. Since the District will pay the insurance premiums for the OCIP coverages described in this manual, you should notify your insurer(s) to delete from your insurance program charges and coverage for the on-site activities of this Project that are covered under the OCIP.

**Note:** Insurance coverage and limits provided by the OCIP are specific to this project. Your insurance representative should review this information. Any additional coverage you may wish to purchase will be at your option and expense. In the event that a General Contractor or a Prime Contractor defaults on their financial obligation to the District, it is the responsibility of the District to notify the OCIP of the default. Before a new contractor is selected by the surety, the contractor must meet the OCIP safety requirements before they can be considered for replacement.

The District reserves the right to terminate or modify the OCIP or any portion thereof. If the District exercises this right, Enrolled Contractors and Subcontractors of any tier will be provided notice as required by the terms of their individual Contracts. At its option, the District may procure alternate coverage or may require Contractors and Subcontractors of any tier to procure and maintain alternate insurance coverage.

To enroll in the program, the "Request for Insurance" Form 2, included in this manual, must be completely filled out and returned to Arthur J. Gallagher & Co. along with the insurance Certificate described in Section V, Enrollment Procedures. Coverage under the OCIP is mandatory but not automatic for all eligible Contractors. Your participation in the OCIP is not complete until you receive confirmation from the OCIP Administrator at Arthur J. Gallagher & Co.

Since your subcontractors will also be covered by the OCIP while performing work at the project site, it is important that you provide a list of all subcontractors to the Construction Manager and Arthur J. Gallagher & Co. Once identified, your subcontractors will receive a copy of this manual.

Should you have any questions regarding the OCIP, please contact:

Arthur J. Gallagher & Co.	Heather Lawson	
National Wrap-up Administration	P. 314.800.2205	
12444 Powerscourt Drive	F. 866.741.2481	
St. Louis, MO 63131		
Arthur J. Gallagher & Co.	Marco Guardi	P. 949.349.9884
18201 Von Karman, Suite 200	John G. Chino	P. 949.349.9800 ext. 827
Irvine, CA 92612	Jackie Godinez	P. 949.349.9800 ext. 825
949.349.9800		

ASCIP, the District and Arthur J. Gallagher & Co. are committed to safety on the job site and expect all contractors to share in this commitment.

## II. Coverage summary

This section outlines the coverages provided for you by the OCIP. The District makes no warranty or representation that the OCIP coverages constitute an insurance portfolio, which adequately addresses all the risks faced by the contractor. Permission is granted by the District should you desire to supplement coverages provided by the OCIP at your expense.

Disclaimer: The information in this manual is intended to outline the OCIP. IF any conflict exists between this manual and the OCIP insurance policies or Contracts between the District and Contractor, the policies or Contracts will govern.

# Workers Compensation and Employers Liability

<b>Insurance Carrier:</b>	Liberty Insurance Corporation	
<b>Policy Term:</b>	Date of Contract until project completion	
<b>Named Insured:</b>	ASCIP (Alliance of Schools for Cooperative Insurance Programs and any tier of contractor, subcontractor and sub-subcontractors thereof, or other entity or person while performing work at an ASCIP project and for whom the Owner has agreed by contract to provide an Owner Controlled Insurance Program.)	
<b>Interest:</b>	Covering only on-site operations related to the ASCIP project.	
<b>Limits of Liability:</b>	Workers Compensation Statutory Benefits – Applicable States	
<b>Employers Liability:</b>	Bodily Injury by Accident	\$1,000,000 Each Accident
	Bodily Injury by Disease	\$1,000,000 Each Employee
	Bodily Injury by Disease	\$1,000,000 Policy Limit

\* There will be a separate policy issued to each contractor or subcontractor as individual Named Insured. You will receive your policy after all the necessary forms have been completed and your enrollment has been confirmed. The OCIP Insurance Carrier will track Workers Compensation losses associated with this project along with your payroll and will submit this information for inclusion in the calculation of your Experience Modifier.

**NOTE:** This policy applies only to operations related to the project conducted at the location designated below and operations necessary or incidental thereto:

**District:**

**Project Name:**

**Project Address:**

- Coverage Endorsements:**
- 1) Voluntary Compensation
  - 2) Statutory Provision
  - 3) Other States Coverage
  - 4) Minor Illegally Employed – Not Insured
  - 5) Punitive or Exemplary Damages - Uninsurable
  - 6) Unintentional Failure to Disclose Hazards
  - 7) Maritime Exclusion
  - 8) Knowledge and Notice of Occurrence
  - 9) Flying Crew Exclusion

# Commercial General Liability

Insurance Carrier:	Liberty Mutual Fire Insurance Company
Policy Term:	From start of project until substantial completion plus 10 years completed operations.
Named Insured:	<div>1) Alliance of Schools for Cooperative Insurance Programs (ASCIP) and</div> <div>2) All tiers of contractors, subcontractors and sub-subcontractors as their interests may appear, who work on the project and for whom ASCIP Member as agreed by contract to provide coverage under the Owner Controlled Insurance Program.</div>
Interest:	This policy applies only to operations related to the project conducted at the location designated below and operations necessary or incidental thereto:
District:	
Project Name:	
Project Address:	
Limits of Liability:	<div>Primary</div> <div><div>\$4,000,000</div><div>General Aggregate, per project</div></div> <div><div>\$4,000,000</div><div>Products/Completed Operations Aggregate</div></div> <div><div>\$2,000,000</div><div>Personal Injury and Advertising Injury</div></div> <div><div>\$2,000,000</div><div>Each Occurrence</div></div> <div><div>\$100,000</div><div>Damage to Premises Rented to You (any one premise and subject to occurrence limit)</div></div> <div><div>\$5,000</div><div>Medical Expense Limit (any one person and subject to occurrence limit)</div></div>
Coverage Endorsements:	<div>Products/Completed Operations - coverage to be extended for 120 months after substantial completion of all work at project site.</div> <div>Broad Form Named Insured</div> <div>Bodily Injury Redefined</div> <div>Advertisement Redefined</div> <div>Unintentional Failure to Disclose Hazards</div> <div>Notice of Occurrence (see Coverage Glossary)</div> <div>Knowledge of Occurrence (see Coverage Glossary)</div> <div>Reasonable Force</div> <div>Broaden Damage to Premise Rented to You Coverage</div> <div>Professional Health Care Srvs by Employees Coverage</div> <div>Bodily Injury to Co-Employees Coverage</div> <div>Non-Cumulation of Liability</div>



**Limitations:**

This policy does not apply to any of the following as Insureds:

- 1) Any person or organization while fabricating or manufacturing materials away from the designated locations,
- 2) Any contractor, subcontractor, supplier, vendor, or common carrier who will have employees engaged in work at the project location who are not provided Workers Compensation and Employers Liability coverage under the Owner Controlled Insurance Program,
- 3) Any architect, engineer, or surveyor and their consultant, relating to professional liability,
- 4) Any other person or organization while transporting equipment to or from the designated location,
- 5) ***Any person or organization that has not completed enrollment in the OCIP.***

**Key Exclusions:**

Aircraft, Auto or Watercraft  
Employment Related Practices  
Broad Form Nuclear  
Engineers, Architects or Surveyors Professional Liability  
Asbestos  
Discrimination  
Total Pollution  
Exclusion of Certified Acts of Terrorism  
Alaska Exclusion of Certified Acts of Terrorism  
Nuclear Energy Liability Exclusion  
Fungi, Bacteria or Mold  
Rip & Tear  
Professional Liability  
Recording and Distribution of Material or Information in Violation of Law

## Coverage Glossary

### NOTICE OF OCCURRENCE

The rights of the Named Insured shall not be prejudiced under this policy, if there is a failure to give notice of an occurrence solely due to the Insured's reasonable belief that bodily injury or property damage is not covered under this policy.

### KNOWLEDGE OF OCCURRENCE

Coverage is to be modified so that it is understood and agreed that knowledge of an occurrence by the agent, servant or employee of the insured shall not in itself constitute knowledge to the insured unless the Insured's corporate insurance department shall have received first notice from its agent, service or employee.

### UNINTENTIONAL NON-DISCLOSURE OF HAZARDS

The unintentional failure of the Named Insured to disclose all hazards existing as of the effective date of this policy shall not prejudice any insured with respect to the insurance afforded by the policy.

# Excess Liability

<b>Insurance Carrier:</b>	Westchester Surplus Lines Insurance Company
<b>Policy Term:</b>	From date bound until project substantial completion plus 10 years completed operations
<b>Named Insured:</b>	Alliance of Schools for Cooperative Insurance Programs (ASCIP) and all tiers of enrolled contractors and subcontractors
<b>Interest:</b>	Coverage in respect of the Insured's on-site operations, solely with respect to the construction of the specified ASCIP projects.
<b>Limits of Liability:</b>	<div>\$15,000,000 Each Occurrence</div> <div>\$15,000,000 General Aggregate</div>
<b>Conditions:</b>	Terms and conditions per policy on file with ASCIP and the District. Defense is inside policy limits
<b>Key Exclusions:</b>	<div>Asbestos</div> <div>CCC (R&amp;P)</div> <div>Discrimination</div> <div>Aircraft products</div> <div>Employment related practices</div> <div>Total pollution</div> <div>Nuclear</div> <div>Professional liability</div> <div>Violation of communication laws</div>

# Builders Risk Insurance

ASCIP has arranged necessary Builders Risk insurance for the project during the entire construction phase for ASCIP Member District\*. The coverage protects the interest of all involved parties including the District, ASCIP and all contractors and subcontractors. This insurance does not protect certain property of contractors used at the construction site, including contractors' tools and equipment (including office trailers, tool sheds and any other temporary structures) not intended to become a permanent part of the project. The following are details of the coverage:

<b>Named Insured:</b>	Alliance of Schools for Cooperative Insurance Programs (ASCIP)
<b>Contractors' Interest:</b>	Contractor's Interest in property covered to the extent of the Insured's liability by law or assumed by contract whether written or oral.
<b>Property Insured:</b>	Real and Personal Property including construction materials intended to become a permanent part of the project. Direct physical loss or damage to materials and supplies while in transit and at temporary storage sites is also covered.
<b>Location Insured:</b>	Specified project site.
<b>Property Not Insured:</b>	Including, but not limited to, all property of contractors and subcontractors which is not incorporated into the project. Examples of this are contractors' tools, machinery, cranes, earthmoving equipment, consumables, office trailers, tool sheds and any other temporary structures not intended to become a permanent part of the project.
<b>Valuation:</b>	Repair or replacement coverage on all insured property.
<b>Limit of Protection:</b>	\$50,000,000 per occurrence blanket real and personal property damage caused by "All Risk" perils per policy form.
<b>Deductible:</b>	This project's deductible is located in the contract documents.

**\* The Builders Risk coverage shall only apply for those ASCIP Member Districts participating in the ASCIP Core Property Program.**

## Owners Protective Professional Indemnity and Contractors Pollution Liability

<b>Insurance Carrier:</b>	Berkley Assurance Company
<b>Policy Term:</b>	November 1, 2017 to February 1, 2021
<b>Named Insured:</b>	<ol style="list-style-type: none"> <li>1) Alliance of Schools for Cooperative Insurance Programs (ASCIP) and</li> <li>2) All tiers of contractors, subcontractors and sub-subcontractors as their interests may appear, who work on the project and for whom ASCIP Member as agreed by contract to provide coverage under the Owner Controlled Insurance Program.</li> </ol>
<b>Limits of Liability:</b>	<p>\$15,000,000 Each Claim</p> <p>\$15,000,000 Policy Aggregate</p>
<b>Notable Endorsements &amp; Exclusions:</b>	<ul style="list-style-type: none"> <li>• Service of Suit Clause – California</li> <li>• Exclusion of Certified Acts of Terrorism</li> <li>• Exclusion of Terrorism</li> <li>• U.S. Economic Trade Sanctions Endorsement</li> <li>• Nuclear Energy Liability Exclusion</li> <li>• Terrorism Exclusion Endorsement</li> <li>• Cap on Losses from Certified Acts of Terrorism Endorsement</li> <li>• Biological Pollution Liability Endorsement</li> <li>• Defense Costs Outside the Limit of Liability</li> <li>• Nose Endorsement</li> <li>• Site Pollution Liability for Insured Property Endorsement – Sudden &amp; Accidental Form A</li> <li>• Site Pollution Liability for Insured Property Endorsement – Sudden &amp; Accidental Form B</li> <li>• Addition of Supplemental Coverage Endorsement – Pre-Claims Assistance</li> <li>• Storage Tank Third Party Liability, Corrective Action and Cleanup Costs – Sudden &amp; Accidental Endorsement</li> <li>• Storage Tank Third Party Liability, Corrective Action and Cleanup Costs Endorsement</li> </ul>

### III. Coverages Not Included in the OCIP

1. AUTOMOBILE INSURANCE

The OCIP does not include Automobile Liability and Physical Damage Insurance for licensed vehicles.

2. OFF-SITE WORKERS COMPENSATION

The OCIP only covers work-related injuries occurring at the work site. It does not cover Workers Compensation risks associated with your other jobs or activities.

3. OFF-SITE GENERAL LIABILITY

The OCIP only covers third-party liability claims arising from activities at the work site. It does not cover liability risks associated with your other jobs or activities.

4. TOOLS, EQUIPMENT AND MACHINERY

The OCIP does not cover loss of, or damage to, your tools and equipment at the job site. Nor does it cover your employee's tools or equipment. Other property such as scaffolds, machinery, crane, earth-moving equipment, consumables, not intended to become a permanent part of the project are not covered under this OCIP.

## IV. Contractors' Safety Requirements

### MINIMUM SAFETY REQUIREMENTS:

Minimum qualifications for contractor enrollment are subject to the following:

- EMR – 1.25 or less as reported by the Workers Compensation Insurance Rating Bureau
- Drug Program Pre-Assignment to job site
- 6' Fall Protection, harnesses and lanyards required in lieu of other protective means. Exceptions: ladders, scissor lifts, aerial baskets or scaffolding
- No more than 5 serious violations within 5 years
- No more than 2 serious repeat in 5 years
- No willful violations
- Hardhats & Safety Glasses are required at all times & other Personal Protective Eyewear (PPE) as required by work being conducted

### SAFETY PROGRAMS

Each contractor will have a written safety program on the job site.

- Each prime contractor is completely responsible for compliance of all its sub-contractors safety requirements.
- District Project Construction Manager will be provided with a copy of all programs.
- Each contractor will maintain on-site a written Hazard Communication/Employer Right-to-Know Program (GHS). A copy will be provided for District's Construction Manager.
- Each contractor's safety activities will be audited based on requirements of its own safety program. Certain minimum standards will apply.
- Subcontractors or sub-subcontractors, which may not now have a written program, may elect to fall under their prime's safety program.
- Should that option be used, each sub or sub-sub is required to submit a letter to the District's Construction Manager indicating it will use that option, that he has a copy of the program and is familiar with the safety requirements under that program and intends to comply with it. Those subs and sub-subs will be held to the same standard as the prime whose program they elect to use.
- Should a prime or subcontractor not currently have a written safety and hazard communication program, Arthur J. Gallagher & Co. will provide an outline of a generic program for use by the contractor in structuring its own version, should it choose.
- Straight adoption of these programs will not be an acceptable option. Each contractor's safety program must be tailored by that contractor to reflect the specific exposures encountered by its tradesmen. Arthur J. Gallagher & Co. and Liberty Mutual Insurance Company will offer assistance in this area if requested.
- All contractors should submit their safety programs to the District's Construction Manager before they begin work.

### SAFETY COMMITTEE

Each prime and those major subcontractors selected by the ASCIP's Construction Manager will appoint a Safety Coordinator.

- Safety Coordinators will be required to attend a Safety Training Session by Arthur J. Gallagher & Co. and Liberty Mutual Insurance at the time of the pre-construction conference.
- The Safety Coordinators will form the Safety Committee.
- Safety Committee Meetings will be held as called by the District's Construction Manager. These meetings will usually occur once each month. Attendance by Safety Coordinators is mandatory.
- Safety Coordinators will be required to accompany Arthur J. Gallagher and Liberty Mutual on tours of the job site for the purpose of training in hazard recognition.
- Superintendents/supervisors will be permitted to act as Safety Coordinators.

### ACCIDENT INVESTIGATIONS

Each contractor and subcontractor is required to submit written accident investigations.

- Liberty Mutual Insurance Company and/or Arthur J. Gallagher representatives will make accident investigation forms available for any contractor who does not currently have them.
- Arthur J. Gallagher and/or Liberty Mutual Insurance Company representatives will review all accident investigation reports for quality.

### SAFETY MEETINGS

Each contractor, subcontractor and sub-subcontractor is required to conduct safety meetings on the job site as directed by its established safety program.

- Minimum standards for number and quality of these meetings will be established for the job.
- A notebook of safety talk topics will be maintained the Construction Office for those companies who wish access to additional topics.
- Joint safety meetings may be conducted by or with the prime and/or other subs.
- The resulting safety meeting report must clearly identify each employee listed - by contractor, subcontractor or sub-sub.
- Safety-meeting reports may be reviewed by safety representatives from Arthur J. Gallagher & Co. and/or Liberty Mutual Insurance for quality and timeliness. The results of those reviews will be submitted to ASCIP's Construction Manager for his actions.

### SELF-INSPECTIONS

Each prime and subcontractor must conduct job-site inspections on a regular basis. While these inspections may conform to the requirements of the contractor's own safety program, they are subject to minimum standards established for the job.

- Joint inspections or inspections conducted by a prime contractor for a sub must be identified as such. Documentation of these inspections must clearly identify the name of the person who did the inspection and each of the contractors, subcontractors, and sub-sub for whom the inspection was made.
- Inspection follow-up will be performed by each contractor to ensure corrections have been accomplished.
- The quality of inspections will be audited by Arthur J. Gallagher & Co. and Liberty Mutual Insurance Company loss control personnel and results of those audits provided to the ASCIP Member's Construction Manager for his action.

### JOB SURVEYS

- Liberty Mutual Insurance and/or Arthur J. Gallagher & Co.'s representatives will conduct job-site surveys monthly, in the company of the members of the Safety Committee for the purpose of training these individuals in hazard recognition.
- Suggestions and recommendations resulting from those surveys will be discussed with contractor representatives at the time of the survey where appropriate. Recommendations and suggestions will be discussed during the regular monthly Safety Committee Meetings.
- Findings will be submitted in the loss prevention report directed to the ASCIP Member's Construction Manager for his action.

### RECORD KEEPING AND FILES

#### **IF IT IS NOT RECORDED IN THE PROJECT'S CONSTRUCTION OFFICE, IT HAS NOT BEEN COMPLETED!**

The following required documentation must be in the contractor's safety file in the ASCIP Member's Construction Office. Representatives of Liberty Mutual and Arthur J. Gallagher will review safety program documentation. It is very important that any contractor with questions regarding record keeping contact ASCIP's Construction Manager, Arthur J. Gallagher & Co. or Liberty Mutual Insurance Company's loss control representative for clarification.



The following documentation is required:

- A written safety program
- A written hazard/employee right-to-know program (GHS)
- Safety data sheets conforming to the Global Harmonization Program (GHS)
- Job-site safety meeting reports
- Accident investigations
- Job-site inspections

#### FILE AUDITS

- Safety files may be reviewed by Liberty Mutual and/or Arthur J. Gallagher & Co.'s loss control representatives monthly.
- Comments as to the quantity and quality of contractor's documentation will be addressed to ASCIP Member's Construction Manager for his action.
- Contractors are encouraged to discuss safety record-keeping problems with the representatives of Arthur J. Gallagher & Co. and Liberty Mutual Insurance Company.

#### FILE AUDITS

- I. Safety files may be reviewed by Liberty Mutual and/or Arthur J. Gallagher & Co.'s loss control representatives monthly.
- II. As to the quantity and quality of contractor's documentation will be addressed to ASCIP Member's Construction Manager for his action.
- III. Are encouraged to discuss safety record-keeping problems with the representatives of Arthur J. Gallagher & Co. and Liberty Mutual Insurance Company.

## ASCIP OCIP

### Safety Orientation Pledge Sheet

#### EMPLOYEES

No employee shall be required or knowingly permitted to work in an unsafe environment except for the purpose of making safety corrections and then only after proper precautions have been taken for their protection.

Each employee is responsible for learning and abiding by those rules and regulations, which are applicable to the assigned task and for reporting observed or anticipated hazards to his supervisor immediately. If the hazard is not corrected, the affected employee will report the hazard to the Project Superintendent at the Project Safety Coordinator.

All employees shall observe the following rules of safe conduct:

#### **Courtesy:**

Employees shall observe standards of behavior and conduct their work in a manner to avoid offending any school staff, other construction employees or visitors to the project. Each individual at the project must be given the courtesy that would be extended to one's family or friends.

Personal Protective Equipment (PPE):

Hardhats & Safety Glasses are required at all times & other Personal Protective Equipment (PPE) required by work being conducted

#### **Clothing:**

Clothing suitable for the weather and your work shall be worn. Torn or loose clothing, cuffs or neckwear are hazardous. Short sleeve shirts and long pants are required. Clothing shall be maintained in a clean, neat and repaired fashion. Wording on clothing shall be limited to identification of the employee, the company and any safety related labels.

#### **Vehicles:**

Employees shall park their vehicles in the designated areas only. Operation of vehicles on the job site shall conform to all local traffic laws. The maximum speed limit on the job site is 15 miles per hour.

#### **Tobacco Free Jobsite:**

Tobacco use is not permitted anywhere inside a school building, or near portable fuel tanks or storage areas for other flammable and combustible materials. No smoking signs will be posted near the storage of flammable and combustible materials. Smoking is permitted only in designated areas outside of all school buildings. Use caution when you smoke, dispose of smoking materials carefully. Scratch anywhere matches are not allowed on site.

#### **Intoxicants:**

Drinking intoxicants on the job is forbidden. The use of narcotics, unless authorized by a physician, is forbidden. Either of these unsafe practices is sufficient cause for immediate dismissal. All employees are required to follow the "Drug Policy" which may be part of their company's policies and procedures.

#### **Accidents:**

All employees must immediately notify their supervisor of any injury on the job or any non-injury accident, which involves damage to property or equipment. Employees are required to assist in accident investigations.



**Personal Conduct:**

Indulgence in practical jokes, horseplay, scuffling, wrestling or fighting is strictly prohibited.

**Good Housekeeping:**

Good Housekeeping on the job site is mandatory and every employee must do their part daily to clean up their work area, and to keep the job clean for safety and efficiency.

**Authorized Access:**

Employees shall confine their activities to the areas designated as the work site. Permission shall be obtained by the employee's supervisor from the appropriate school representative prior to entry into any areas outside the work site.

**Fire Protection:**

Employees shall adhere to all fire protection regulations, and shall conduct their work in a manner to preserve the fire safety integrity of the buildings and job site.

**Electrical Outlets:**

Only electrical circuits and outlets designed for the project use may be utilized for construction power.

***Failure to comply with any of the above requirements could result in a monetary fine or removal from the job site.***

**Safety Pledge**

I acknowledge my commitment to observe all project safety rules, regulations and standards and agree to conduct my work in a safe, neat and professional manner.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Employer

\_\_\_\_\_  
Hard Hat Sticker No.

## OCIP

### La Seguridad Orientación Prenda Hoja

#### LOS EMPLEADOS

Ningún empleado se requerirá o a sabiendas se permitirá trabajar en un ambiente inseguro salvo el propósito de hacer las correcciones de seguridad y entonces sólo después de que se han tomado las precauciones apropiadas para su protección.

Cada empleado es responsable por aprender y haber cumplido esas reglas y regulaciones que son aplicable a la tarea asignada y por informar los riesgos observados o anticiparon inmediatamente a su supervisor. Si el riesgo no se corrige, el empleado afectado informará el riesgo al Superintendente del Proyecto al Coordinador de Seguridad de Proyecto.

Todos los empleados observarán las reglas siguientes de conducta segura:

#### La Cortesía:

Los empleados observarán normas de conducta y dirigirán su trabajo de una manera evitar ofender a cualquier personal de la escuela, otros empleados de la construcción o visitantes al proyecto. Cada individual al proyecto debe darse la cortesía que se extendería a la familia de uno o amigos.

#### El Equipo Proteccionista Personal (PPE):

Se llevarán los Sombreros duros en todo momento mientras al proyecto. Mire el testamento de protección se lleve en todo momento al moler, cortando, soldando, mientras cortando o martillando o cuando apropiado para la tarea asignada.

Vistiendo:

Vistiendo conveniente para el tiempo y su trabajo se llevarán. Colgajo o ropa suelta, puños o prendas para el cuello son arriesgados. Las camisas con las mangas cortas son un requisito mínimo. Vistiendo se mantendrán en un limpio, aseado y reparó la moda. Formulando en vestir se limitarán a la identificación del empleado, la compañía y cualquier seguridad relacionaron las etiquetas.

#### Los Vehículos:

Los empleados sólo estacionarán sus vehículos en las áreas designadas. El funcionamiento de vehículos en el sitio del trabajo conformará a las leyes de tráfico todo locales. El límite de velocidad máximo en el sitio del trabajo es 15 millas por hora.

#### Fumando:

Fumando no se permite en cualquier parte dentro de un edificio escolar, o cerca de tanques de combustible portátiles o áreas del almacenamiento para otros materiales inflamables y combustibles. Ninguna señal que fuma se anunciará cerca del almacenamiento de materiales inflamables y combustibles. Fumando sólo se permite en las áreas designadas fuera de todos los edificios de la escuela. Use la cuatela que cuando usted fuma, disponga cuidadosamente de materiales que fuma. Rasque en cualquier parte que los fósforos no se permiten en el sitio.

#### Intoxicants:

El intoxicants bebiendo en el trabajo se prohíbe. El uso de narcóticos, a menos que autorizó por un médico, se prohíbe. Ambas estas prácticas inseguras son la causa suficiente para el despido inmediato. Todos los empleados se exigen seguir la "Política de Droga que puede ser parte de las políticas de su compañía y procedimientos.

#### Los Accidentes:

Todos los empleados deben notificar a su supervisor de cualquier lesión inmediatamente en el trabajo o cualquier accidente del non-lesión que involucren el daño a propiedad o equipo. Se exigen a los empleados que ayuden en las investigaciones del accidente.

**La Conducta Personal:**

La indulgencia en las bromas, payasada, luchando, mientras luchando con o luchando se prohíben estrictamente.

**El Gobierno De La Casa Bueno:**

El Gobierno de la casa bueno en el sitio del trabajo es obligatorio y cada empleado debe hacer su parte diariamente para limpiar su área de trabajo, y guardar el trabajo limpio para la seguridad y eficacia.

**El Acceso Autorizado:**

Los empleados confinarán sus actividades a las áreas designadas como el sitio de trabajo. El permiso se obtendrá por el supervisor del empleado del prior del representante escolar apropiado a la entrada en cualquier área fuera del sitio de trabajo.

**Dispare Protección:**

Los empleados adherirán a las regulaciones de todo las protecciones de fuego, y dirigirá su trabajo de una manera conservar la integridad de seguridad de fuego de los edificios y sitio del trabajo.

**Las Tomas De Corriente Eléctricas:**

Pueden utilizarse sólo circuitos eléctricos y tomas de corriente diseñadas para el uso del proyecto para el poder de la construcción.

***Falta a conformese con cualesquiera de los requisitos podria resultado en una multa monetaria o retiro de el sitio del trabajo.***

**Las Seguridades Empeñan**

Yo reconozco mi compromiso para observar todas las reglas de seguridad de proyecto, regulaciones y normas y estar de acuerdo en dirigir mi trabajo en una caja fuerte, la manera aseada y profesional.

---

La Firma de Empleado

---

La Fecha

---

El Nombre de Patrón

---

La Pegatina del Sombrero Dura No.

## Pre-Assignment Drug Screening Program and Post-Accident Alcohol and Drug Screening

### PURPOSE

The Sponsor of the **Owner Controlled Insurance Program (OCIP)** is committed to protecting people and property and providing a safe working environment. The purpose of this policy is to establish a drug-free, alcohol-free, safe and healthy work environment for each employee working at the project premises.

### POLICY

The **OCIP Sponsor** prohibits the use, possession, distribution, or sale on the project premises, facilities, or work places of any of the following: alcoholic beverages, intoxicants, drugs and related drug paraphernalia.

Employees must not report for duty or perform work while under the influence of any drug, alcoholic beverage, or intoxicant. Employees on the project premises may be subject to search as provided herein. Applicants and employees will be required to consent to drug and alcohol screening or an oral fluid drug screen as provided herein.

### DEFINITIONS

When used herein, the following terms will have the meanings given below:

- a. Company – **General Contractor and/or Prime Contractor** Company and sponsored joint ventures.
- b. OCIP – Owner Controlled Insurance Program
- c. OCIP Sponsor – Alliance of Schools for Cooperative Insurance Programs with its representative and OCIP Administrator, Arthur J. Gallagher & Co.
- d. Alcohol – Ethyl (Ethanol). References to use or possession of alcohol include the use of any beverage, mixture, or preparation containing alcohol.
- e. Drug – Any substance (other than alcohol) including prescription drugs which may impair mental or motor function; including, but not limited to, any psychoactive substance, controlled substance, marijuana, or designer or simulated drugs. This definition does not apply to prescription drugs which have been disclosed to the OCIP, Company and the Controlling Employer by the employee and are approved for use within prescription limits.
- f. Employee – Any individual, salaried or hourly, who actually performs work for a Controlling Employer on the project premises.
- g. Controlling Employer – Any individual or firm that provides employees to perform work on the project premises and is responsible for their hiring, advancement, payment, discipline, and termination. This shall include all contractors, all subcontractors, and all sub-tier subcontractors who are enrolled in the OCIP Program.
- h. Project Premises – All parts of any office, work site, or other work location, including parking lots under the control of the **General Contractor and/or Prime Contractor** Company and covered by the OCIP.
- i. Testing Facilities – A NIDA certified laboratory where a specimen can be tested for drugs and alcohol within threshold limits according to standards established by the U. S. Department of Transportation or oral fluid drug test which meets or exceeds the D.O.T. threshold.
- j. Contraband – Considered to include but not limited to the following: drugs, alcohol, and drug paraphernalia.
- k. Drug Paraphernalia – Any article for the use, storage, or sale of drugs.
- l. Accident – Any event resulting in injury to a person or property to which the OCIP and/or the Company believe an employee contributed as a direct or indirect cause.
- m. Incident – Any event which the OCIP and/or the Company determines has all the attributes of an accident, except that no harm was caused to personnel or property.
- n. Pre-Assignment Screening – screening of employees for drugs, as defined above, prior to commencing work on the project's premises.

This policy is subject to review and acceptance by collective bargaining entities under contract with Company or any Controlling Employers engaged in work on the Project. Company shall not be held liable or responsible for any errors, omissions or negligent acts associated with implementation, administration and enforcement of this policy.



## RIGHT TO SEARCH

The OCIP has the right to search any personal effects, vehicles, lockers, baggage, lunch boxes, tool boxes, etc., for contraband. An individual who has notice of this rule and enters the project premises is deemed to consent to this safety procedure. Searches will be conducted on an "as needed" basis as determined after consultation with the OCIP and Company regional and corporate management. There will be an employee representative and/or other witnesses, which may include law enforcement officers, to all searches conducted by the OCIP or the Company.

An employee who refuses to submit to a search as described in this policy is subject to disciplinary action, up to and including immediate discharge by the Controlling Employer. Contractors and/or employees who refuse to submit to a search are subject to removal and denial of future access to the project premises.

An employee on the project premises, facility, or work place in possession of contraband is subject to disciplinary action, up to and including immediate termination by the Controlling Employer. Contractors and/or employees who are in possession of contraband are subject to removal and denial of future access to the project premises.

## PRESCRIPTION DRUGS

Any employee using a prescription drug which may impair mental or motor function shall, as soon as possible, complete Section 3 of the Consent for Alcohol/Drug Screen and Pre-Assignment Form. For the safety of all employees, the OCIP may direct the Controlling Employer to not permit the employee on the project premises until released as fit for duty by the prescribing physician. The OCIP reserves the right to obtain a confirming medical opinion before allowing the employee to return to duty.

## POST-ACCIDENT TESTING

After an accident or incident, the OCIP will ask the Controlling Employer to test all those involved for alcohol and drugs. In many cases, post-accident testing can occur during the clinic visit for injury treatment. The OCIP will also ask the Controlling Employer to test employees when a reasonable suspicion exists that the employee has been using drugs or alcohol, or is in possession of contraband. Procedure for reasonable cause will consist of one supervisor observing employee demonstrating signs and symptoms of impairment. A second observation will be made by another supervisor independently of the first supervisor. Both supervisors must agree that the employee is exhibiting signs of impairment before the employee will be required to be tested. This Alcohol and Drug test must be conducted in an approved clinic.

## PRE-ASSIGNMENT SCREENING

The OCIP requires evidence of negative screening results from employees using the Oratect® or similar method for drug screening within 72 hours prior to assignment to the project's premises. Controlling employers are expected to arrange for screening its employees and provide screening results to Company as part of the employee assignment process. Employees without evidence of negative screening prior to assignment are not permitted on the project premises. Employees that have received negative results arising from their controlling employers' random or pre-employment drug screening programs within six months prior to assignment are exempt from this requirement. Again, evidence of such results is required to be provided as part of the assignment process.

## DISCIPLINE AND REHABILITATION

All employees who refuse to submit to a drug and alcohol screen, or who fail to pass a drug and alcohol test will be removed from the project premises by the Controlling Employer and will be referred to their personnel management for disciplinary action.

## CONFIDENTIALITY

The OCIP and the Company will take steps to maintain the confidentiality of information generated by the implementation and enforcement of this policy and these procedures. Disclosure will be made only in appropriate circumstances. The Controlling Employer shall be responsible for maintaining the confidentiality of all information generated by the implementation and enforcement of this policy and these procedures for their own employees. The OCIP shall have the right to audit compliance with this policy and these procedures by the Controlling Employer, which shall include access to this confidential information.

## SUBCONTRACTORS AND SUPPLIERS

The Company and all Contractors will include the provisions of this policy and these procedures, or another acceptable program, in their contracts with subcontractors, suppliers, consultants, agents, and others involved in providing goods or services covered by the OCIP, and will require that they do the same with respect to their lower-tier subcontractors, suppliers, etc.

## POSTING AND DISTRIBUTION

Significant sections of this policy and these procedures are available to each employee.

The OCIP may revise and amend this policy and these procedures as required.

## PROCEDURES FOR EXAMINATION

Post-Accident Testing When Required By the OCIP  
(Personal injury or vehicle/equipment accident)

1. A **General Contractor and/or Prime Contractor** Company supervisor is to accompany injured **General Contractor and/or Prime Contractor** employee(s) or those involved in the accident or incident to the clinic or medical facility. A Controlling Employer's supervisor will be required to accompany their injured employee(s) to the medical facility. Controlling Employers shall certify any employee(s) involved in an accident or incident tested negative for drugs and alcohol prior to allowing them to return to the project premises. The Company shall certify any employee(s) involved in an accident or incident tested negative for drugs and alcohol prior to allowing them to return to the project premises.
2. Results of all drug testing and analyses must remain strictly confidential.
3. Employees must report all injuries immediately to their supervisor, whether the injury requires medical treatment or first aid only. Late reporting may result in denial of a claim.

## EMPLOYEE AGREEMENT WITH POLICY AND CONSENT FOR ALCOHOL AND DRUG SCREENING

The following form is to be completed for all **General Contractor and or Prime Contractor** employees. All Controlling Employers shall obtain and submit to **General Contractor** a completed consent form from each employee who will be working on the project premises. This form can be attached to the employee's safety pledge form.

During the course of construction, the **General Contractor** will assist the OCIP in the administration of the Drug Testing/Drug Free Workplace Program.



## V. Enrollment Procedures

1. Enroll online at: <https://ajg.vuewrapup.com/contractorportal>. Enrollment instructions on page after sample certificate.
2. Upload a certificate of insurance to the website where you enroll in accordance with the OCIP enrollment provisions in the General Conditions evidencing primary Auto Liability and Workers Compensation, and General Liability for Project-Related Operations performed away from the OCIP Project Site. Contact your Insurance Agent for this certificate (a sample is included). It is your responsibility to notify your Insurance Agent to exclude all work to be done at this Project Site from your regular GL and WC policies.
3. Arthur J. Gallagher will send a Certificate of Insurance evidencing your coverage under the ASCIP/OCIP program. This certificate is required by the District to obtain access to the job site. You should keep this certificate as evidence of your participation in the OCIP. It may be required by your regular insurance company

If you have any questions please contact the OCIP administrator:

Heather Lawson  
Arthur J. Gallagher & Co.  
National Wrap up Unit  
12444 Powers Court Drive  
St. Louis, MO 63131  
O. 314.800.2205  
M. 314.330.6917  
F. 866.741.2481  
[heather\\_lawson@ajg.com](mailto:heather_lawson@ajg.com)

# Online VUE System

To start please open your internet browser and go to the AJG Wrap-up Management Portal URL (<https://ajg.vuewrapup.com/contractorportal>). This will open the portal login screen.

**Gallagher**  
Insurance | Risk Management | Consulting

Welcome to VUE Wrap-Up™ Contractor Portal!

VUE Wrap-Up™ organizes subcontractor communications, eliminates paperwork and reduces manual intervention and electronically organizes documents to eliminate the need for paper filing systems.

You can provide and manage the following information from our Contractor portal.

- Enrollment Information.
- Monthly Payroll.
- Insurance Cost Information.
- Submit Certificate of Insurance.
- Submit policy's Declaration and Rate pages.
- Award your subcontractors.
- CIP Manuals.
- Claims Reporting Instructions.

If you are not already registered, please Register yourself via the link below.

**REGISTER ME**

Already registered user?  
URL has been expired. Please check once.

Enter your Username

Enter your Password

**LOGIN** ☐ Remember User Name

[Trouble logging in?](#)

First time users please click here to register.

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## Step 1: Registering and Logging In

Click the **Register Me** link at the bottom right hand corner of the login box. **If you are already registered, proceed to Step C.**

- Fill in the form with your first name, last name, email ID (email address) and enter the user ID you would like to use. Your user ID can be any name or phrase you will easily remember, such as your first initial and last name (preferred), your company name, or your email address. Password must contain letters, numbers and symbols. All fields are required.

# Online VUE System

**Gallagher**  
Insurance | Risk Management | Consulting

### Register in VUE Wrap-Up Contractor Portal!

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You can provide and manage the following information from our Contractor portal.

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- CIP Manuals.
- Claims Reporting Instructions.

#### New User Registration

First Name  
Last Name  
FEIN  
Email ID  
User Name  
Password  
Confirm Password

☐ I agree to the Terms and Conditions and Privacy Policy.

CANCEL SUBMIT

- B. When your registration has been completed successfully, you will see the message **“User ID and Password are created”**. Please click [here to login to “Contractor Portal”](#). Click the link to be redirected to the login page where you can login to the portal to complete your enrollment. You will also receive an email with your User ID and Password for your records.
- C. Use your provided or created User ID and Password to login. If any error messages appear, contact your AJG Wrap-up Administrator.

## Step 2: Completing an Enrollment

- A. If your incomplete enrollment already has a contract in the system, you may be required to fill in the missing details. Your contract can be selected by clicking on the contract number hyperlink in the Contract # column.

Welcome: Tali Kirkwood [ Sample Contractor ]  
Last Login Time: 07/05/18 07:33 PM EST

[Inbox](#) [Home](#) [Password](#) [Add User](#) [Logout](#)

Hello, you are logged into the Contractor Portal.

For new and returning users who need to create a new enrollment record, please add [NEW ENROLLMENT](#).

[Payroll](#) | [Documents](#) | [View Subcontract](#) | [Insurance Cost Worksheet](#) | [Close Out](#)

	Contract #	Project	Contractor	Start Date	End Date	Contract Status	Contract Value
<input type="checkbox"/>	<a href="#">14999999-006</a>	Test Project	Sample Contractor	07/05/2018		New	\$25,000.00
<input type="checkbox"/>	<a href="#">14999999-016</a>	Test Project	Sample Contractor	07/04/2018	12/31/2018	Incomplete	\$25,000.00
<input type="checkbox"/>	<a href="#">CTP-00</a>	CSSI Test Project	CSSI Test Contractor	07/01/2018	12/31/2020	Enrolled	\$25,000.00

1 - 3 of 3 items 50 items per page

- B. If you do not see a contract for the specific project you are enrolling in, click the “New Enrollment” button.

# Online VUE System

Hello, you are logged into the Contractor Portal.

For new and returning users who need to create a new enrollment record, please add [NEW ENROLLMENT](#).

[Payroll](#) | [Documents](#) | [View Subcontract](#) | [Insurance Cost Worksheet](#) | [Close Out](#)

**Contract Listing**

	Contract #	Project	Contractor	Start Date	End Date	Contract Status	Contract Value
<input type="checkbox"/>	14999999-006	Test Project	Sample Contractor	07/05/2018		New	\$25,000.00
<input type="checkbox"/>	14999999-016	Test Project	Sample Contractor	07/04/2018	12/31/2018	Incomplete	\$25,000.00
<input type="checkbox"/>	CTP-00	CSSI Test Project	CSSI Test Contractor	07/01/2018	12/31/2020	Enrolled	\$25,000.00

- C. When the user clicks on the [New Enrollment](#) link, a pop up screen will open as shown below. Users should provide the Project Code as listed in their Wrap Up manual or provided by their Wrap Up Administrator.

Project code verification

Please provide the valid project code in order to begin new enrollment

## Step 3: Enrolling

- A. The Enrollment Screen includes the following sections, each of which can be expanded or collapsed for ease of review:
- Provide Company Information
  - Provide Contract Information
  - Provide Contact Information
  - Provide Address Information
  - Provide Estimated Payroll for work performed on the Contract
  - Provide Offsite Insurance Information
  - Provide Additional Information
  - Approval and Signature

Application For Enrollment

In order for your company to be considered enrolled and covered under the Wrap Up Insurance, you must complete the details below. Any missing information may result in your contract being incomplete and could delay insurance coverage. You will receive notices for any missing details required to complete and process your application. If you do not qualify for Wrap Up coverage, we will notify you. If your company qualifies for coverage and once all enrollment details have been provided, you will receive a copy of your Welcome Letter and Certificate of Insurance evidencing coverage in the Wrap Up.

Expand All Collapse All

Provide Company Information

Provide Contract Information

Provide Contact Information

Provide Address Information

Provide Estimated Payroll for work performed on this Contract

Provide Additional Information

As noted in the CCIP Manual, Swinerton will purchase General Liability and Excess Coverages for the benefit of participating subcontractors. In exchange for this benefit, the undersigned agrees as follows:

This submitted information accurately reflects the total projected insurance costs (for bidder and all subcontractors noted on this form) that would apply if my regular insurance program were to provide coverage for this work. I agree that Swinerton will apply the above insurance deducts, based on subcontractor's normal cost of insurance. This deduct will be taken from a submitted pay application. Subcontractors enrolled in the PLP program will be responsible for an insurance deductible obligation which will range from \$1,000-\$25,000 per occurrence for General Liability, if determined the subcontractor is liable for the associated claim. For losses falling within the Products/Completed Operations period, the

☐ I agree that the statements in this application are true and accurate to the best of my knowledge.

Signature (print your name)\*

Enrollment Date 07/05/2018

PRINT SUBMIT SAVE FOR LATER

- B. Fill in each section with your information to the best of your ability. Every section is required to be completed.
- For a new enrollment, all fields should be filled in.
    - If your company has previously enrolled in a contract on our portal, you will have an option to select previous information in some fields

Please select an existing address record or add a new address by completing the fields below. If you wish to provide more than one address you can do so by clicking on the 'Add' button. Note: You must select one address record as "Primary".







Select Existing Address



- If a contract has been added to your portal by an AJG Wrap-up Administrator, you may not be able to edit some fields. Move on from those and fill in all the other fields as completely as possible.
- If you notice a mistake in a non-editable field, contact your AJG Wrap-up Administrator.
- If you are not sure what a field is requesting, hovering over the field title will show captioned explanations.

- C. In the Contact section you must enter at least one contact and it must be marked as primary. You may also add additional contacts i.e. Payroll Contact or Worker's Comp Claim Con

The screenshot shows a window titled "Provide Contact Information". It contains two identical contact entry forms. Each form has a "Contact Type\*" dropdown menu with "Select" as the current choice. To the right of each form is a "Primary" checkbox. The first form's "Primary" checkbox is checked, while the second's is unchecked. Both forms have input fields for "First Name\*", "Last Name", "Email\*", and "Mobile", and a "Phone" field. The "Email\*" field is highlighted in yellow in both. Below the first form are two buttons: a red minus button and an orange eraser button. Below the second form are three buttons: a red minus button, an orange eraser button, and a green plus button.

- a. You must provide a value for your corresponding preferred mode of contact. For example, if you select email as your preferred method of contact, you must provide an email address.
- b. If the enrolling contractor has existing contacts available in our system, they can make a selection from the existing records by selecting contact information from the dropdown available on top of each contact box. Once selected, the contact details will be populated in the respective fields.
- c. User can manually enter the new contact by performing these steps: Select contact type, from dropdown menu; enter *First Name*, *Last Name*, *Email*, *Phone*, and *Mobile*. By default, the Primary checkbox will be marked for the first contact added. Please note, that the email is mandatory.
- d. To add an additional contact, click the ADD  button
- e. Once a second Contact is added the CLEAR  and DELETE  button will be available for existing Contact block, allowing the user to clear the details and re-enter or delete the record if needed.
- D. In the Address section, enter a primary address by filling in all fields and checking the checkbox "Primary". You must enter at least one address, and if there is only one it must be marked as primary.
- a. To add a secondary address, click the ADD  button in the lower left hand corner of the section containing that address.
- b. Once another address is added, the CLEAR  and DELETE  button will be displayed for the existing Address block, allowing the user to clear the details and re-enter or delete the record if needed
- c. Note: You cannot delete an address that has already been approved by the AJG Wrap-up Administrator. If there is an error in the address approved or entered by the AJG Wrap-up Administrator, please contact them directly.

**Provide Address Information**

Address Type\* Select

Primary ☒

Street Address 1\*


Street Address 2

City\*

State\* Select

Zip\*



- E. In the Estimated Payroll section, you must enter your best estimate of payroll for entirety of the project.
- You must submit estimated payroll for **all** Worker's Compensation Codes you will be working under on the project. To add estimated payroll for additional codes, please press the Add  button on the lower right hand corner of the section.

**Provide Estimated Payroll for work performed on this Contract**

State CA

If the Classification Code was not found in the drop down, please click to [Add New Class Code](#)

Class Code	Man Hours	Estimated Payroll (\$)
 <span>Select</span>	<input type="text"/>	<input type="text"/>

- F. The Insurance Information section is required:
- Risk ID # (This is the ID # assigned to the Contractor by the Rating Bureau that compiles and calculates the EMR).
  - Rating Bureau (The organization that compiles Claims history and Payroll to calculate the EMR).
  - EMR value for current year.
  - Anniversary Rating Date (MM/DD/YYYY) when the new EMR shall come into effect.
- (Note: Please contact your Insurance Broker to obtain any offsite policy details if you do not have them.)

**Provide Offsite Insurance Information**

Risk ID

Rating Bureau Select

EMR



Anniversary Rating Date

WC Carrier

WC Offsite Policy #

Policy Effective Date

Policy Expiration Date



## Online VUE System

- G. Before you submit your enrollment information, you must check the confirmation checkbox. (Note: The text in your portal may differ from what is shown in the screenshot.) Once you have verified that all information entered is correct, please check the checkbox, and type your name in the Signature box.

This submitted information accurately reflects the total projected insurance costs (for bidder and all subcontractors noted on this form) that would apply if my regular insurance program were to provide coverage for this work. I agree that Swinerton will apply the above insurance deducts, based on subcontractor's normal cost of insurance. This deduct will be taken from a submitted pay application. Subcontractors enrolled in the PLP program will be responsible for an insurance deductible obligation which will range from \$1,000-\$25,000 per occurrence for General Liability, if determined the subcontractor is liable for the associated claim. For losses falling within the Products/Completed Operations period, the deductible obligations will double.

☐ I agree that the statements in this application are true and accurate to the best of my knowledge.

Signature (print your name)\*

Enrollment Date 07/05/2018

- H. If you do not have all the necessary information needed for your enrollment, you are now allowed to save the information that you have input and come back to finish at a later time.



After pressing the Save for Later or Submit button be sure to confirm your selection before leaving the page. If you do not, your enrollment will not be saved or submitted in any way.

You are about to submit your enrollment application. Click "Yes" to submit, click "No" to review and make changes.

- I. Once your Contract is submitted, you cannot make changes to the enrollment.

### Step 4: Uploading Documentation

- A. As part of your enrollment, you **are** be required to submit supporting documentation:
- Certificates of Insurance
  - NKLL (No Known Loss Letters – if you've been on site for over 30 days before enrolling)

The system will prompt you as to which documents are required



# Online VUE System

**Documents**

For now we will show the following message until Product team gives us the ability to show these bullets based on the selected settings. Please upload the following documents, as they may be required to process your enrollment. If you are unsure what documents are required, you should refer to your CIP Insurance manual for a complete listing.

- Workers' Compensation Declaration and Rate Pages
- General Liability Declaration and Rate Pages
- Excess Declaration and Rate Pages
- Offsite COI

Contract # CTP-00

Select Document Category

<input type="checkbox"/> COI Reviews/Renewals	<input type="checkbox"/> Enrollment
<input type="checkbox"/> Excess Dec & Rate Pages	<input type="checkbox"/> GL Dec & Rate Pages
<input type="checkbox"/> Insurance Cost Worksheet	<input type="checkbox"/> No Known Loss Letter
<input type="checkbox"/> Notice of Completion	<input type="checkbox"/> Other Documents

Select File  **BROWSE**

**UPLOAD FILE**

Document Category	Document Name	File Name	Document Date
CIP Manual	CIP Manual	GC-ChelseMontrose.pdf	07/01/2018

## B. Accessing the Documents screen

- Once you have submitted your enrollment you can press the Documents button on the top Right

Contract #: CTP-00      Project: CSSI Test Project (CTP)      Contract Status: Enrolled      Administrator's Review: Approved

The enrollment has already been submitted. You cannot make any more changes. Please contact your Wrap-Up Administrator for further assistance.

**DOCUMENTS**      SUBCONTRACTS

Expand All      Collapse All

- On the Documents screen you must choose from the Select Document Category and Select File to upload the document. Refer to the image below. If there are existing document(s) for the selected Contract, the system will display those under Documents section.

**Documents**

For now we will show the following message until Product team gives us the ability to show these bullets based on the selected settings. Please upload the following documents, as they may be required to process your enrollment. If you are unsure what documents are required, you should refer to your CIP Insurance manual for a complete listing.

- Workers' Compensation Declaration and Rate Pages
- General Liability Declaration and Rate Pages
- Excess Declaration and Rate Pages
- Offsite COI

Contract # CTP-00

Select Document Category

<input type="checkbox"/> COI Reviews/Renewals	<input type="checkbox"/> Enrollment
<input type="checkbox"/> Excess Dec & Rate Pages	<input type="checkbox"/> GL Dec & Rate Pages
<input type="checkbox"/> Insurance Cost Worksheet	<input type="checkbox"/> No Known Loss Letter
<input type="checkbox"/> Notice of Completion	<input type="checkbox"/> Other Documents


Select File  **BROWSE**

**UPLOAD FILE**

Document Category	Document Name	File Name	Document Date
CIP Manual	CIP Manual	GC-ChelseMontrose.pdf	07/01/2018

## D.

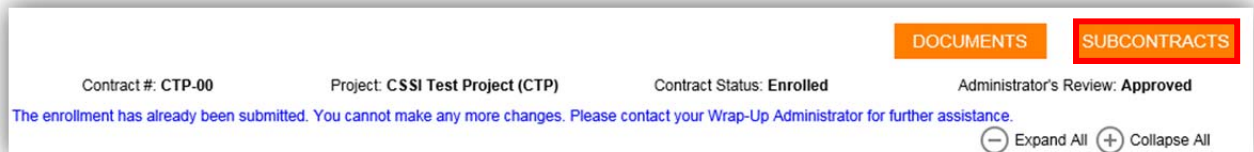
- E. To add the documents to the selected Contract, follow the steps below:
- Select the Document Category from the available options. Note: A user can select multiple Categories, i.e. "GL Dec and Rate Pages" and "Excess Rate and Dec Pages"
  - To locate the file to upload, browse your local drive by clicking on the Browse button. The file must be available on your device or computer from which you are currently accessing the portal.
  - Once the file is successfully uploaded, the document(s) will be listed in the Documents section of the Documents Screen.

**Notes:**  Only PDF, DOC, DOCX or TIFF documents can be uploaded and all files must be 10MB or under

## Step 5: Adding a Subcontract

If you need to add a Lower Tier Subcontractor please follow the below instructions

- A. From the Enrollment Screen select the Subcontract button on the top right hand corner



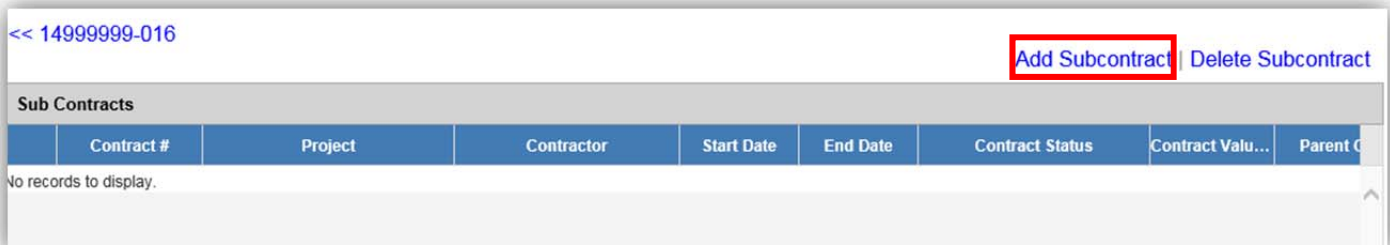
Contract #: CTP-00      Project: CSSI Test Project (CTP)      Contract Status: Enrolled      Administrator's Review: Approved

The enrollment has already been submitted. You cannot make any more changes. Please contact your Wrap-Up Administrator for further assistance.

[DOCUMENTS](#) [SUBCONTRACTS](#)

⊖ Expand All ⊕ Collapse All

- B. This will bring you to the Sub Contract Screen. Begin by pressing the Add Subcontract button



<< 14999999-016

[Add Subcontract](#) [Delete Subcontract](#)

Sub Contracts								
Contract #	Project	Contractor	Start Date	End Date	Contract Status	Contract Valu...	Parent C	
No records to display.								

- C. This will open a Sub Contract enrollment Screen
- Please fill out all information to the best of your ability
  - Business Name, FEIN # (If known), Subcontract Value, Expected Start Date
  - Contract # is a read only field.
  - Verify the information and check the checkbox next to the statement "Statements in this application are true and accurate to the best of my knowledge"
  - Press Submit and confirm

**Sub Contract** - Test Project / 14999999-016

Contract #

Business Name\*  Federal ID #

Business Type\*

Contract Start Date\*  Contract Value\*

If you are self performing any work, please indicate the amount of your contract that is self performed.

Description of Work\*

**Contact Info**

First Name\*  Last Name

Email\*  Mobile

Phone

**Payroll Contact Info**

☐ Same as above

First Name  Last Name

☐ Email  Mobile

Phone

☐ Statements in this application are true and accurate to the best of my knowledge.\*

D. To add an additional subcontracts; click on the Add Sub Contract button again the first Sub Contract screen.

## Step 6: Reporting Payroll Online

Payroll is required to be submitted **monthly** online by **5<sup>th</sup>** of each month unless otherwise specify, by **all** Subcontractors on jobs that cover Worker's Compensation.

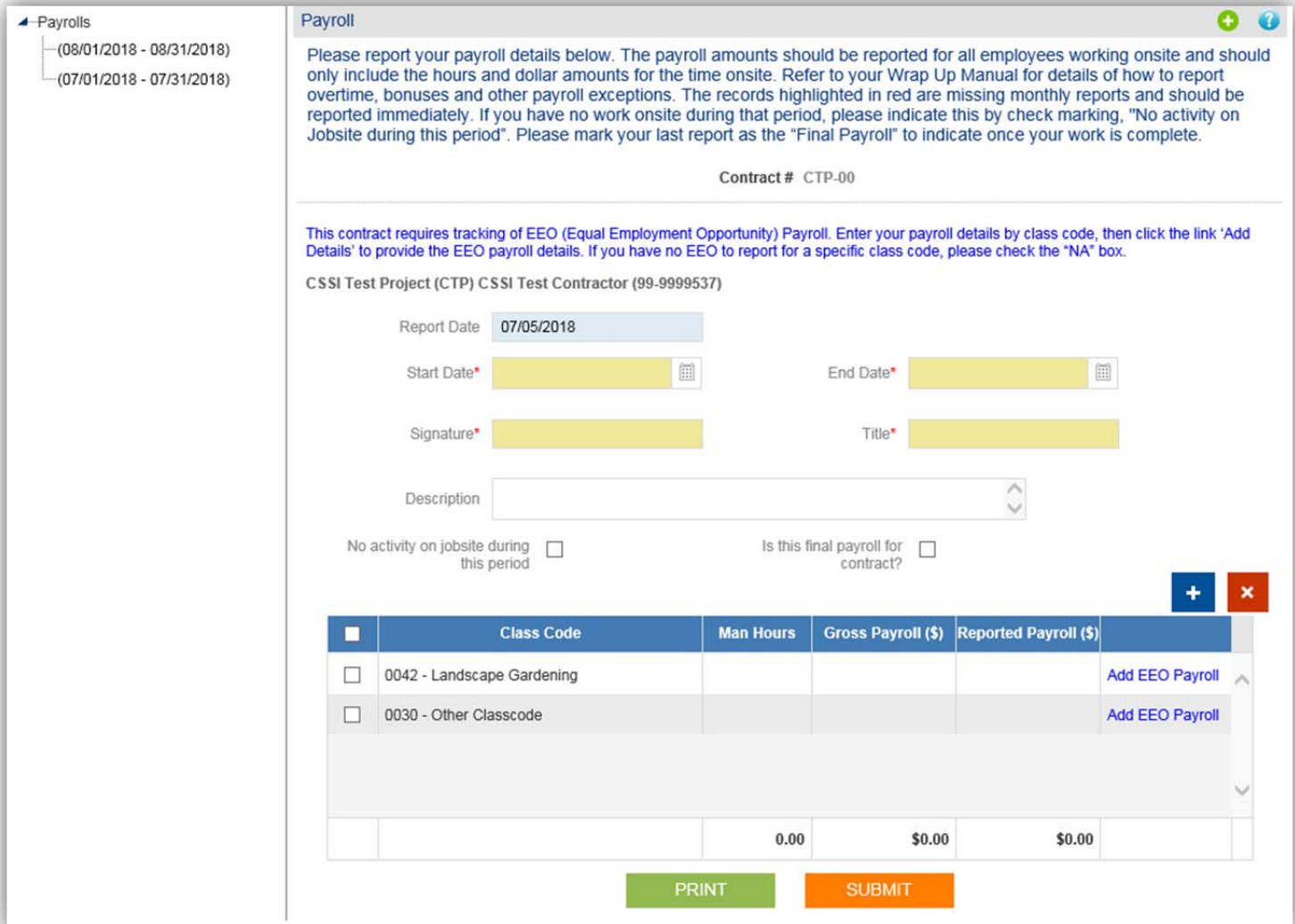
- A. Once logged in to the portal site check the box next to the Contract # listed on the Home Screen, then Click on the Payroll button above.
- a. **Note:** If any of your Contract #'s are not listed, please contact your AJG Wrap-up AJG Wrap-up Administrator to check the status of enrollment.

Contract Listing					
	Contract #	Project	Contractor	Start Date	End Date
<input type="checkbox"/>	14999999-006	Test Project	Sample Contractor	07/05/2018	
<input type="checkbox"/>	14999999-016	Test Project	Sample Contractor	07/04/2018	12/31/2018
<input checked="" type="checkbox"/>	CTP-00	CSSI Test Project	CSSI Test Contractor	07/01/2018	12/31/2020

Payroll Documents | View Subcontract

## Online VUE System

- B. Report date is the current date, and will be filled by the System. (any dates in red, are delinquent payroll that must also be submitted. You can enter payroll for these dates by pressing them and filling in the information.)



Payroll

Please report your payroll details below. The payroll amounts should be reported for all employees working onsite and should only include the hours and dollar amounts for the time onsite. Refer to your Wrap Up Manual for details of how to report overtime, bonuses and other payroll exceptions. The records highlighted in red are missing monthly reports and should be reported immediately. If you have no work onsite during that period, please indicate this by check marking, "No activity on Jobsite during this period". Please mark your last report as the "Final Payroll" to indicate once your work is complete.

Contract # CTP-00

This contract requires tracking of EEO (Equal Employment Opportunity) Payroll. Enter your payroll details by class code, then click the link 'Add Details' to provide the EEO payroll details. If you have no EEO to report for a specific class code, please check the "NA" box.

CSSI Test Project (CTP) CSSI Test Contractor (99-9999537)

Report Date 07/05/2018

Start Date\* End Date\*

Signature\* Title\*

Description

No activity on jobsite during this period ☐ Is this final payroll for contract? ☐

	Class Code	Man Hours	Gross Payroll (\$)	Reported Payroll (\$)	
<input type="checkbox"/>	0042 - Landscape Gardening				Add EEO Payroll
<input type="checkbox"/>	0030 - Other Classcode				Add EEO Payroll
		0.00	\$0.00	\$0.00	

PRINT SUBMIT

- C. If this is the first payroll report, please enter the Start Date by either manually typing in Date textbox (MM/DD/YYYY), or using the drop down Calendar. Do the same for the End Date. While submitting subsequent payrolls, the System will populate the next calendar day as the Start Date from the previous report. The dates must be the whole month i.e. Start Date: June 1 End Date: June 30. Unless your contract starts or ends in the middle of a month.
- D. On the payroll screen, the WC Code(s) will be filled from the estimated payroll you submitted during enrollment.
- E. If you need to add another WC code, click on the blue plus button located on the top right of the payroll chart.
- In the WC Code box, enter the WC Code followed by the Description in the next field. In addition, you can delete a selected WC Code by clicking the Delete (x) icon located above the Reported Payroll column.  
**Note:** You must leave a note in the notes field explaining to the AJG Wrap-up Administrator why you are entering payroll for a class code not included on your enrollment.
- F. Click the Man Hours field to enter the correct hours. Enter the Unburdened Payroll (straight time: no overtime premium, taxes, union dues, etc...)
- Remember:** If there are no hours worked for a WC code for that month, enter zero (0) in all fields

## Online VUE System

- G. If no time was worked on site for that month, please check box next to “check the No Activity on jobsite this period box” and submit.

No activity on jobsite during this period ☐

- H. If you are entering Final Payroll, please check box next to “Is Final Payroll for contract?”

Is this final payroll for contract? ☐

- I. After all required information has been entered, click the Submit button. **Please note:** Once the payroll information has been submitted it is still editable and can be resubmitted as needed. If you are unable to edit please contact the AJG Wrap-up AJG Wrap-up Administrator for changes.
- J. To print, click Print button on the top right corner of Actual Payroll screen. A PDF file will open displaying the details of the submitted Actual Payroll.

### Step 7: Close Out

- A. Once logged in to the portal site select the Contract # listed on the Home Screen, then Click on the Close Out button.
- a. Note: If any of your Contract #'s are not listed, please contact your AJG Wrap-up AJG Wrap-up Administrator to check the status of enrollment.

The screenshot shows the 'Contract Listing' table with columns: Contract #, Project, Contractor, Start Date, End Date, Contract Status, and Contract Value. A red box highlights the checkbox next to the first contract (14999999-006). A red arrow points from this checkbox to the 'Close Out' button in the top right corner of the interface.

	Contract #	Project	Contractor	Start Date	End Date	Contract Status	Contract Value
<input type="checkbox"/>	14999999-006	Test Project	Sample Contractor	07/05/2018		New	\$25,000.00
<input type="checkbox"/>	14999999-016	Test Project	Sample Contractor	07/04/2018	12/31/2018	Incomplete	\$25,000.00
<input type="checkbox"/>	CTD-00	CSSI Test Project	CSSI Test Contractor	07/01/2018	12/31/2020	Enrolled	\$25,000.00

- B. Please fill out all fields
- Notice of Completion Date: the day your company finished work on site.
  - Completion Signature: The name of whomever is completing the form
  - Final Contract Value: Your final contract value with you Prime Contractor
  - Payroll Information: The final payroll amount for all Class Codes from your enrollment, for the entire project. Once all information is completed, please press the Submit button. You will see the message “Data Saved Successfully”
  - NOTE: The payroll box will auto fill with the totals from your monthly payroll submissions. If the total does not match, you must go through your reported payroll for each month and edit as necessary. Once you have edited you may press the “Refresh Payroll” button and submit

## Online VUE System

Contract Close Out

By completing the details below, you are indicating that your work on this project is complete and you no longer have any employees returning to the jobsite. Please refer to your Wrap Up manual to confirm whether or not a Non CIP COI is required to return to the jobsite.

Contract # CTP-00

Notice of Completion Date\*

Completion Signature\*

Tali Kirkwood

Final Closeout Information

Final CV\*

Refresh Payroll

+

×

<input type="checkbox"/>	Class Code	Final Man Hours	Final Payroll (\$)
<input type="checkbox"/>	0042 - Landscape Gardening	10.00	\$1,000.00
<input type="checkbox"/>	0030 - Other Classcode	0.00	\$0.00
		10.00	\$1,000.00

PRINT

SUBMIT



<b>ACORD<sup>TM</sup> CERTIFICATE OF LIABILITY INSURANCE</b>						DATE (MM/DD/YYYY) 01/01/1001	
<b>PRODUCER</b> Your Insurance Agent				<b>THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.</b>			
<b>INSURED</b> Your Company Name				<b>INSURERS AFFORDING COVERAGE</b>		<b>NAIC #</b>	
INSURER A: Your Insurance Company				INSURER B: Your Insurance Company		INSURER C:	
INSURER D:				INSURER E:		NAIC #	
<b>COVERAGES</b>							
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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.							
INSR LTR	ADD'L INSR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	<input type="checkbox"/>	<b>GENERAL LIABILITY</b> <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR	123456789	01/01/1001	01/01/1001	EACH OCCURRENCE	\$ 1,000,000
		GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC				DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 50,000
						MED EXP (Any one person)	\$ 5,000
						PERSONAL & ADV INJURY	\$ 1,000,000
						GENERAL AGGREGATE	\$ 2,000,000
						PRODUCTS - COMP/OP AGG	\$ 1,000,000
A	<input type="checkbox"/>	<b>AUTOMOBILE LIABILITY</b> <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS	123456789	01/01/1001	01/01/1001	<b>COMBINED SINGLE LIMIT (Ea accident)</b> \$ 1,000,000	
		<b>BODILY INJURY (Per person)</b> \$ 0					
		<b>BODILY INJURY (Per accident)</b> \$ 0					
		<b>PROPERTY DAMAGE (Per accident)</b> \$ 0					
A	<input type="checkbox"/>	<b>EXCESS/UMBRELLA LIABILITY</b> <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$	123456789	01/01/1001	01/01/1001	<b>AUTO ONLY - EA ACCIDENT</b> \$	
		<b>OTHER THAN AUTO ONLY:</b> EA ACC \$					
		<b>AGGREGATE</b> \$					
		<b>RETENTION</b> \$					
A	<input type="checkbox"/>	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	123456789	01/01/1001	01/01/1001	<input type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER	
		<b>E.L. EACH ACCIDENT</b> \$ 1,000,000					
		<b>E.L. DISEASE - EA EMPLOYEE</b> \$ 1,000,000					
		<b>E.L. DISEASE - POLICY LIMIT</b> \$ 1,000,000					
<b>OTHER</b>							
<b>DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS</b>							
Additional Insured for off site general liability and both on and off site auto liability, waiver of subrogation for off site workers' compensation in favor of Downey Unified School District, <del>XXXXXXXXXX</del> , and Arthur J. Gallagher Risk Management Services, Inc.; additional endorsement required - primary and non-contributory. Please note, it is your responsibility to notify your insurance agent to exclude all on site work for this job site from your regular WC and policies once you receive a CIP certificate from AJG.							
<b>CERTIFICATE HOLDER</b>				<b>CANCELLATION</b>			
Alliance of Schools For Cooperative Insurance Program C/O: Arthur J. Gallagher & Company 12444 Powerscourt Drive Suite 500 St. Louis, MO 63131				SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL <u>30</u> DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE			

ACORD 25 (2001/08)

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FORMS



## Liberty Mutual Group MPN

### Form B – Employee Notification Confirmation

In order to confirm that you have received appropriate notification regarding the Liberty Mutual Group Medical Provider Network (MPN) please complete and sign the attached form. This form must be returned to your employer at the time you first receive employee notification information about the MPN. This may occur at the time of your employer's MPN presentation, at the time of hire, at the time of your report of injury or at the time you transfer into the MPN.

Employee Signature	Date
Print Employee Full Name	
Name of Employer	

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.

---

Con el fin de confirmar que usted ha recibido la notificación adecuada acerca de la Red de Profesionales de Servicios Médicos del Grupo Liberty Mutual (MPN) (**Liberty Mutual Group Medical Provider Network** (MPN)) por favor llene y firme la forma adjunta. Esta forma debe ser entregada a su empleador al momento en que reciba información de la notificación para empleados acerca de la MPN. Esto puede ocurrir al momento de la presentación de la MPN de su empleador, al momento de la contratación, al momento de su reporte de lesión o al momento de su traslado a la MPN.

Firma del empleado	Fecha
Nombre firma completo	
Nombre del empleador	

Cualquier persona que hace o provoca conscientemente cualquier declaración o representación material falsa o fraudulenta para propósitos de obtener o de negar los beneficios de compensación o pagos de los trabajadores es culpable de un delito grave.

Fax Completed Form to 949.349.9900.

**Medical Provider Network Locations**



## Medical Provider Network

Recent changes in California's workers compensation law, specifically SB 899, 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.

In response to these changes, your employer has implemented a MPN, effective February 3, 2005 for any workers compensation claims. Your employer has chosen the Liberty Mutual Group MPN that has been approved by the state. For all work-related injury or illness the physicians and providers in the Liberty Mutual Group MPN will provide you with medical treatment and services.

Below is a summary of the Liberty Mutual Group MPN and your responsibilities if you have a work-related injury or illness. You have also received more detailed information regarding the MPN with this letter.

**PROVIDER PREDESIGNATION** – You may pre-designate your physician(s) prior to injury if you have previously received care with the physician(s). The attached form (Form A) must be signed by you and the physician(s) must agree to be your primary treating physician. If the physician(s) does not agree to continue as your primary treating physician then you will be required to seek medical care with a physician in the MPN.

**IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS** – If you need emergency care go to the nearest medical center and contact the number above as soon as possible but no later than forty-eight hours after emergency treatment. For non-emergency situations, you may use either your pre-designated physician or contact your supervisor to find out which initial treating MPN provider is available. The MPN has primary treating physicians and providers that are available within 15 miles or 30 minutes or specialty care within 30 miles or 60 minutes from your work or residence. For initial treatment the MPN physician will schedule an appointment for you within 3 business days from the date you request treatment within the MPN. If you require additional services beyond your initial visit, you may use any provider, appropriate to your injury, within the MPN. If you have difficulty in getting an appointment or need any assistance in locating a provider contact your supervisor or the Claims Case Manager.

**IF YOU ALREADY HAVE A WC CLAIM AT THE TIME YOU RECEIVE THIS NOTICE** – Contact your supervisor. You may qualify to continue treatment with your current provider under the Liberty Mutual Group MPN Transfer of Care Plan if your condition is acute, serious or chronic, if treatment is for remission, is to prevent deterioration, is a terminal illness or for a scheduled surgery or procedure that will occur within 180 days. Contact your supervisor or Claims Case Manager for questions or advice on your options.

**OBTAINING AUTHORIZATION PRIOR TO TREATMENT** – Your treating physician must obtain prior authorization for medical treatment and services. The following requests should be directed through Liberty Mutual's Utilization Management department by calling the toll-free number of 1-800-664-CARE (2273): Diagnostic tests, in-patient hospitalization, occupational therapy, outpatient surgery & procedures and pain management including; IDET and nucleoplasty procedures, injections, acupuncture, morphine pumps and spinal cord stimulators, physical therapy, psychiatric treatment and work conditioning and work hardening. The Liberty Mutual Utilization Review Unit will review your physician's treatment or service request to determine the medical necessity and will render a certified (approval) or non-certified (non-approval) decision. You and your physician will receive a utilization review determination notification letter. Non-utilization review treatment areas that the Liberty Mutual Claims Case Manager or Nurse Case Manager may review include: Durable Medical Equipment, Home Nursing Care, Medications, Office Visits, except psychiatric treatment, routine laboratory tests and treatment evaluations other than physical therapy, occupational therapy and chiropractic evaluations. For these non-utilization review treatment areas you will be notified as to the authorization or non-authorization of your physician's request by the Claims Case Manager or Nurse Case Manager.

**APPEAL PROCESS FOR NON-CERTIFICATIONS** – If your medical treatment or service request is non-certified you may request an appeal by following the Appeal instructions in the utilization review determination notification letter.

**PHYSICIAN CHANGE AND REQUESTS FOR A SECOND OR THIRD OPINION** – You may change physicians within the MPN at any time as long as the provider is appropriate to treat your injury. If you dispute the diagnosis or treatment prescribed by your treating physician, you may request two additional opinions from other MPN physicians. To file a dispute, you must inform your employer or the Claims Case Manager that you dispute your treating physician's opinion and request a second or third opinion. You must select a physician or specialist from the list that your employer has of the available MPN providers and make an appointment with the second or third opinion physician within 60 days. You must notify the Claims Case Manager of your appointment date. If the appointment is not scheduled within 60 days of receipt of the list of the available MPN providers, then you will have waived your rights to the second and third opinion process with regard to this disputed diagnosis or treatment of this treating physician. During this process, you must continue your treatment with your current treating physician or with another physician of your choice within the MPN. At the time of selection of the third opinion physician, if you dispute the second

physician's opinion, the Claims Case Manager will notify you about the Independent Medical Review process and provide you with an "Application for Independent Review" form. If you need assistance contact your supervisor or your Claims Case Manager.

**TERMINATED MPN PROVIDERS AND CONTINUITY OF CARE** – If your physician terminates from the MPN, we will advise you on your options for continued treatment as approved under the Liberty Mutual Group MPN Continuity of Care Plan. In some instances, the terminated physician may continue to treat you through the Continuity of Care plan. Copies of the plan are available upon request. Contact your supervisor or Claims Case Manager if you have questions or need advice on your options.

**CONFIRMATION OF RECEIPT OF NOTIFICATION INFORMATION** – In order to confirm that you have received appropriate notification regarding the Liberty Mutual Group MPN please complete and sign the attached form (Form B). Form B must be returned to your supervisor or Claims Case Manager at the time you first receive employee notification information about the MPN. This may occur at the time your employer distributes information about the MPN, at the time of hire, at the time of your report of injury or at the time you transfer into the MPN.

For any questions relating to the MPN, Compensability, Benefits, Continuity of Care Plan or Transfer of Care Plan please contact your supervisor or your Claims Case Manager.

To report a workers compensation injury or illness, please immediately contact your employer or the Claims Case Manager at the above listed telephone number.

## Medical Clinic

### Construction Program

Form #1 – Master Policy Number:

#### WORKERS COMPENSATION TREATMENT AUTHORIZATION

PROJECT NAME:	ASCIP/OCIP – Project –	
CONTRACTOR NAME:		
CONTACT PERSON:		
CONTACT ADDRESS:		
BUSINESS ADDRESS:		
SITE PHONE#:	BUS PHONE/FAX:	
<b>EMPLOYEE INFORMATION</b>		
EMPLOYEE NAME:		
EMPLOYEE ADDRESS:		
EMPLOYEE TELEPHONE #:		
EMPLOYEE SSN:		
HARD HAT STICKER #:	EMPLOYEE DATE OF BIRTH:	
EMPLOYEE OCCUPATION:		
DATE OF INJURY:		
<p><b>Contact Liberty Mutual at (800) 821-0967 Fax: (603) 334-0231 for any questions and for referral to specialist authorization.</b></p>		
PROVIDER NAME:		
<b>TREATMENT AUTHORIZED BY</b>		
	_____ (Signature of Employee's Supervisor)	
	_____ (Employee's Signature)	
<b>SEND BILLS TO:</b>	Liberty Mutual P.O. Box 989000, W. Sacramento, CA 95798-9000 T. 800.821.0967, F. 603.334.0231	
<b>PROVIDER</b>		
	_____ (Authorized Signature)	
<p><b>Referrals to medical specialist must be pre-authorized by Liberty Mutual at (800) 821-0967</b></p>		

DIAGNOSIS/RECOMMENDATIONS	
Return to work / Treatment Completed:	
Continue Medical Treatment / Estimated Date of Completion:	
Liberty Mutual Claim Number:	

## Liberty Mutual Insurance

### Injured Employee & Foreman's Responsibilities Workers Compensation

1. If injury is serious call 911.
2. Injured employee reports directly to the employees supervisor
3. If employee can be treated on site for a minor cut (Band-Aid type wound) etc. Provide first aid and log injury on the first aid log located in the CM/GC trailer. Advise the employee of the location and if appropriate, the date and time, when Medical treatment will be given. If injury is life-threatening call 9-1-1 and have employee taken to nearest medical facility qualified to treat the condition.
4. It is the responsibility of the employer of the injured employee to report the injury to the information on the Workers' Treatment Authorization Form
5. The injured employee and their supervisor should complete the Workers Compensation Treatment Authorization Form so you will have the answers to the questions when you call Liberty Mutual. Keep the original form in the CM/GC trailer.

CALL LIBERTY MUTUAL INSURANCE AT 800.641.1723 AND REPORT INCIDENT (WITHIN 24 HRS).

6. If the employee needs a doctor, fill out Form #1 – **(Workers Compensation Treatment Authorization – MEDICAL CLINIC)** and take the injured employee (and the form) to the medical provider.



## How to Report an 800 # Claim

**CALL 800.641.1723 WITHIN 24 HOURS OF LOSS!**

**When reporting a claim please give the following information:**

**1. OWNER/INSURED**

- ASCIP – Alliance of Schools for Cooperative Insurance Programs
  - ASCIP Master Work Comp Policy#
  - ASCIP Master General Liability Policy #

**2. OCIP PROJECT SITE CODE & PROJECT LOCATION**

- Site Code:
  - Location:
  - Address:

**3. (SUB)/CONTRACTOR'S COMPANY NAME (YOUR EMPLOYER):**

---

**4. (SUB)/CONTRACTOR'S OCIP WC POLICY # (found on your CIP cert)**

---

**NOTE:** Please document the 800 # reporting representative on the claim reporting form

Name of #800 Claim Reporting Representative:

---

Name of Claim Adjuster Assigned:

---

Claim Number Assigned:

---

Please proceed with the claim reporting form.

IF YOU HAVE ANY PROBLEMS REPORTING YOUR CLAIM PLEASE

CALL: YVETTE ROBINSON AT 213-443-0774

## WHEN AN INJURY OCCURS, WHAT SHOULD BE DONE?

### EMPLOYEE:

1. The Injured Employee must report the injury to their Employer/ Supervisor



If the injury is serious or  
life-threatening,  
  
CALL 911 IMMEDIATELY



### FIRST AID TREATMENT:

If the employee can be treated on-site for minor scratches, cuts, burns, splinters, etc.,

1. Provide appropriate first aid.
2. Log the injury on the "Illness and Injury" log located in the Construction Manager/ General Contractor's trailer.

### EMPLOYER/SUPERVISOR:

2. Within 24 Hours from the time that the Employer/Supervisor is notified by the employee of the injury, state law requires that the Employer/Supervisor provide the DWC Form 1 Claim Form to the injured employee. If the employee refuses medical treatment at this time, the Employer/Supervisor must still provide the DWC Form 1 identifying the affected body part(s) to the injured employee. (A copy of this form must be sent to Liberty Mutual after you have received it back from the injured employee.)
3. The Employer/Supervisor must provide the Injured Employee with the OCIP Workers Compensation Treatment Authorization Form and send the injured employee to the pre-assigned clinic/hospital emergency room for treatment.
  - If the employee needs a doctor, provide him or her with Form #1 – Workers Compensation Treatment Authorization – Medical Clinic.
4. The Employer/Supervisor is recommended to go to the clinic with the injured employee.
5. The Employer/Supervisor should conduct a complete investigation of the injury and immediately call Liberty Mutual Insurance at (800) 641-1723 to report the incident.
6. After reporting the claim to the Liberty Mutual 1-800 number, the Employer/Supervisor must record the claim number that Liberty Mutual provides and retain for their records.
7. Notify the doctor that you can provide light duty or modified work for the injured employee. (Let Liberty Mutual know if you are unable to provide light duty within the doctor-indicated work restrictions.)

### EMPLOYER/SUPERVISOR:

#### PLEASE NOTE:

- If there is doubt of this being a legitimate injury, you must still send the injured employee to the clinic. Call Liberty Mutual and the clinic to inform them that this is a questionable injury.
- After reporting the claim to the Liberty Mutual 1-800 number, Liberty Mutual shall forward the "Form 5020 Employers First Report of Occupational Injury" to the Employer/Supervisor.



#### RED FLAGS

- A delayed report or blind claim
- A brand new employee
- Injuries not consistent with the facts of the accident
- Injuries occurring early Monday morning, Friday afternoon or evening, at lunchtime, or at the beginning or end of work shift
- An un-witnessed injury
- An injury report following disciplinary action or following an announcement of impending reduction in force or other employee perceived threat to job security.

**NOTIFY LIBERTY MUTUAL  
IMMEDIATELY IF YOU HAVE ANY  
DOUBT ABOUT THIS BEING A VALID  
CLAIM**

**REPORTING WORKERS  
COMPENSATION FRAUD  
IS EVERYONE'S  
RESPONSIBILITY!**



# Contractors’ Responsibility for Reporting Claims

TYPE OF INCIDENTS

- 1. **INJURY TO ANY WORKER ON THE JOB SITE** – contractor required following the instructions listed on the following page.
- 2. **INJURY TO ANY SCHOOL DISTRICT PERSONNEL** – injury should immediately be reported to the construction manager and the injured party should be assisted by the contractor until relieved by district personnel
- 3. **INJURY TO ANY OTHER PARTY** – parent, child, pedestrian, etc. the construction manager should immediately be notified and the incident should be called into the Arthur J. Gallagher & Co. construction unit at 949.349.9884 with all of the information shown immediately below.

Name of Injured Person:	
Address:	
Phone Number:	
Brief Description of Injury/Severity:	
Where was patient taken for treatment:	

**Supervisor's Accident Investigation Report****Instructions on following page**

<b>I. GENERAL INFORMATION</b>		
COMPANY NAME	PROJECT NAME	
EMPLOYEE NAME	JOB TITLE	
EMPLOYEE HARD HAT STICKER NUMBER	GENDER (M/F)	
DATE OF ACCIDENT	TIME OF ACCIDENT	
TYPE OF ACCIDENT/ILLNESS		
TYPE OF INJURY		
PART OF BODY INJURED	TREATMENT	DID EMPLOYEE RETURN TO WORK THE SAME DAY?
<b>II. DESCRIPTION</b>		
WHERE AND HOW DID THE ACCIDENT HAPPEN? (Use additional sheets if necessary)		
<b>III. CAUSES</b>		
SPECIFY MACHINE, TOOL, SUBSTANCE OR OBJECT CONNECTED WITH THE ACCIDENT		
UNSAFE MECHANICAL/PHYSICAL/ENVIRONMENTAL CONDITION AT TIME OF ACCIDENT (Be Specific)		
PERSONAL FACTORS (Attitude, Lack of Knowledge or Skill, Slow Reaction, Fatigue)		
PERSONAL PROTECTIVE EQUIPMENT REQUIRED		
WAS INJURED EMPLOYEE USING REQUIRED EQUIPMENT		
<b>IV. RECOMMENDATIONS</b>		
ACTION PLAN TO PREVENT RECURRENCE (Modification of Machine, Mechanical Guarding, Environment, Training)		
_____ SUPERVISOR'S SIGNATURE		_____ DATE
<b>V. FOLLOW-UP</b>		
ACTIONS TAKEN ON RECOMMENDATIONS (Include Date Completed)		



## Instructions For Completing Accident Report

**Please print or type all information. Complete report in as much detail as possible.**

### 1. GENERAL INFORMATION

Fill in all information requested. Name of person injured, date, exact location, job title, job being performed, etc., For description of type of accident/illness, injury and body part, see the following.

A. Type of Accident/Illness	B. Type of Injury	C. Part of Body Injured (Select as many needed)
<ul style="list-style-type: none"> <li>• slip/fall</li> <li>• struck by/against</li> <li>• caught in/on/between</li> <li>• contact with/by</li> <li>• over-exertion/lifting</li> <li>• burn by</li> <li>• cut by</li> <li>• amputation</li> </ul>	<ul style="list-style-type: none"> <li>• cut</li> <li>• bruise</li> <li>• puncture</li> <li>• abrasion</li> <li>• strain</li> <li>• sprain</li> <li>• burn</li> <li>• irritation</li> <li>• swelling</li> <li>• fracture</li> </ul>	<ul style="list-style-type: none"> <li>• thumb/finger/hand/wrist</li> <li>• elbow/arm/shoulder</li> <li>• toe/foot/ankle</li> <li>• leg/knee/hip</li> <li>• head/neck/face</li> <li>• nose/eye/ear/throat</li> <li>• chest/abdomen</li> <li>• upper back/lower back</li> </ul>

### 2. DESCRIPTION OF ACCIDENT

Describe in as much detail as possible where and how the accident happened. This section is for facts, not opinions. Statements the injured or witnesses made should be detailed. Use an additional piece of paper if more space is needed. Include sketches or photos if they help explain what happened.

### 3. CAUSES

Identify and describe in detail type of equipment, tools, processes etc., unsafe conditions (mechanical, physical, environmental) and/or personal factors involved in the accident. Discuss the use and requirements regarding any personal protective equipment.

### 4. RECOMMENDATIONS

Once causes are identified, action must be taken to prevent the same thing from happening again. Realistic yet effective recommendations should be implemented. The form should be signed and dated by the appropriate supervisor.

### 5. FOLLOW UP

List actions which have been taken and their respective completion date. Proper follow-up should continue on any incomplete recommendations.

**Consent for Pre-Assignment Drug Screen and Post-Accident Alcohol and Drug Screen**

To:

Name of Employer

From:

Employee Name

Social Security #

Occupation

Company Badge

Home Address

Phone

1. As an Employee, I hereby consent and agree to give specimens of my urine or oral fluid (saliva) to any medical facility, laboratory, medical person, or certified personnel designated by **the OCIP**. These specimens shall be used to detect the presence of alcohol (post-accident only), marijuana and/or other drugs in my body. I further consent and agree that the results will be furnished to my employer by the testing facility, and my employer may inform the Union hiring hall (if applicable) which referred me of my pass/fail results.
2. If APPROVED for ASSIGNMENT or PRESENTLY EMPLOYED and in the event that I am directly or indirectly involved in a work related accident or incident, or the OCIP/company has reasonable suspicion of a drug or alcohol problem involving me, I consent and agree to screening for the presence of alcohol and drugs in my body. The screening facility is authorized to release the results of such screens to my employer. I, further acknowledge that I have received a copy of a summary of the **OCIP's** policy on drugs, alcohol and other prohibited articles and agree to screening in accordance with this policy. If any screens and confirming results are positive, the **OCIP and the General Contractor** may refuse to permit me access to the project premises. My signature below acknowledges that I have read and understand the foregoing statements and the consent given herein.
3. Are you, at the present time, taking any medicine, tranquilizers, sedatives, pills, capsules, tablets, or liquids that may impair your ability to safely work on the project premises? ☐ YES ☐ NO

Medication	Prescribing Doctor

READ BEFORE SIGNING

IF YOU DON'T UNDERSTAND, ASK FOR AN EXPLANATION.

Employee Signature

Date

Employer's Authorized Company Representative

Date

## **Results of Pre-Employment Drug Test**

All workers before coming on the job site are required to have a pre-job drug test. The certificate of cleanliness is required to be presented to the CM/GC/Prime along with the other required sign off sheets.

## Oratect® III (and OratectPlus®)

### STEP 1: TO BE COMPLETED BY COLLECTOR (Please Print Clearly)

Donor Name (Last, First, M) \_\_\_\_\_

Donor ID Number \_\_\_\_\_

☐ License ☐ Other

Reason for test:

☐ Pre-employment ☐ Random ☐ For Cause ☐ Periodic

☐ Post-accident ☐ Return to Duty ☐ Other (Specify) \_\_\_\_\_

### STEP 2: TO BE COMPLETED BY COLLECTOR

Collection Date: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.

**Collector certification:** I certify that the Oratect™ screen for drugs of abuse was administered by me for the donor identified above and that the picture below is of the device used by that donor.

Collector Signature \_\_\_\_\_

Collector Name (printed) \_\_\_\_\_

Oratect™ should be placed face up in this area (face down on copy machine)

### STEP 3: TO BE COMPLETED BY DONOR

**Donor Consent:** I consent to the collection of my oral fluid specimen for the purpose of screening for drugs of abuse and/or alcohol. I understand that this test is a screen and that if the results should indicate **non-negative/inconclusive** for any drug group, a second confirmatory test will be performed prior to final determination. I consent to the reporting of results only to the employer or requesting agency.

Donor Signature \_\_\_\_\_

Date \_\_\_\_\_

### STEP 4: SCREENING RESULTS & CONFIRMATION PROCESS (IF NEEDED)

Screening Results:

☐ Negative (no drugs present)

☐ Inconclusive (additional testing needed)





## Consentimiento Para Examen de Droga y Alcohol

Proporcionaremos un proceso de prueba profesional y confidencial. Si Usted tiene alguna pregunta o preocupacion con respecto a nuestro procedimiento, favor de hacerzelo saber al recaudador a la hora de hacer su examen. Una vez que tengamos los resultados de su examen se lo proporcionaremos a Usted y a su empleador. Usted tiene la opción de rechazar el examen de drogas. Sin embargo, si Usted se niega a hacer el examen, se le pedira que se retire inmediatamente del sitio de trabajo.

### PASO 1: SER COMPLETADO POR COLLECTOR

Nombre de Donante \_\_\_\_\_

Numero de Identificacion de Donante \_\_\_\_\_

☐ Licencia ☐ Otra

Razon para la prueba: \_\_\_\_\_

☐ Pre-empleo ☐ Post-accidente ☐ Re- Ingreso

### PASO 2: SER COMPLETADO POR DONANTE

Yo conciento a la coleccion de mis fluidos orales para el proposito del examen de drogas y/o alcohol. Comprendo que si mis resultados no son claramente negativos, necesitare proveer una muestra de orina que sera enviada al laboratorio.. Tambien comprendo que si el resultado de mi examen de alcohol es de .04 o mas me pediran que conceda a un examen de alcohol de aliento para confirmacion. Certifico que la informacion que proporcione en esta forma es cierta y correcta.

Firma de Donante \_\_\_\_\_

Fecha \_\_\_\_\_

### PASO 3: RESULTADOS DE EXAMEN

Resultado de Examen de Droga: \_\_\_\_\_

☐ Negativo ☐ Enviado al Laboratorio

Resultado de Examen de Alcohol: \_\_\_\_\_

☐ Negativo (Bajo .04) ☐ .04 O Mas

*Yo, el donante, observe y estoy de acuerdo que mis fluidos fueron usados para obtener los resultados antes mencionados.*

Nombre de Donante \_\_\_\_\_

Firma de Donante \_\_\_\_\_

### PASO 4: SER COMPLETADO POR COLLECTOR

Collection Date: \_\_\_\_\_

Time: \_\_\_\_\_

a.m. /p.m.

**Collector certification:** I certify that the Oratect™ screen for drugs of abuse was administered by me for the donor identified above and that the picture below is of the device used by that donor.

Collector Signature \_\_\_\_\_

Collector Name (printed) \_\_\_\_\_

Place the Oratect® III in this area



**Illness and Injury Log****OWNER CONTROLLED INSURANCE PROGRAM  
ILLNESS AND INJURY LOG**

NO.	EMPLOYEE NAME	CONTRACTOR NAME	HARD HAT STICKER #	DATE OF INJURY	TIME OF INJURY	TYPE OF INJURY	TREATMENT FIRST AID OR DOCTOR'S VISIT
#001							
#002							
#003							
#004							
#005							
#006							
#007							
#008							
#009							
#010							
#011							
#012							
#013							
#014							
#015							
#016							
#017							
#018							
#019							
#020							
#021							
#022							

ALL ILLNESSES OR INJURIES MUST BE RECORDED ON THIS FORM

## Hard Hat Sticker Check List

## OWNER CONTROLLED INSURANCE PROGRAM HARD HAT STICKER CHECKLIST

[illegible]