STATEWIDE EDUCATIONAL WRAP UP PROGRAM (SEWUP) JPA

Owner Controlled Insurance Program (OCIP) 2006-2008

Program Administrator:

SEWUP Department
2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501

License # 0451271

San Mateo County Community College

Project Insurance Manual

STATEWIDE EDUCATIONAL WRAP UP PROGRAM (SEWUP) JPA
OWNER CONTROLLED INSURANCE PROGRAM (OCIP)

Project Insurance Manual

Program Administrator:

Keenan & Associates
2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501
Phone: (800) 654-8102
SEWUP Department
Fax: (310) 787-8838

License # 0451271

Table of Contents

Section 1

1.0 Introduction

The Statewide Educational Wrap Up Program JPA (SEWUP), of which San Mateo County Community College District is a member, is providing an Owner Controlled Insurance Program for worked performed at specific project sites.

1.1 Preface

The OCIP provides the following insurance for all eligible and enrolled contractors, regardless of tier, that are approved for participation in the OCIP.

- Workers' Compensation
- Commercial General Liability
- Excess Liability
- Builder's Risk
- Contractor's Pollution Liability

The OCIP coverage will be provided for each eligible contractor, of every tier, under contract. SEWUP's Program Administrator, Keenan & Associates, ("Keenan") will be administering the OCIP on behalf of the District. The OCIP will be primary insurance for the benefit of insured parties. All premiums for coverages listed above will be paid by the District.

Consult your contract regarding your liability for deductible portions under any policies provided by the District.

> **Note**
>
> The guidelines in this manual are to be used for general purposes only. If any conflict exists between this document and any contract or subcontract; the contract or subcontract will govern.

1.2 Program Expectations

According to industry practices, it is the responsibility of all contractors, of every tier, to exercise reasonable care to prevent work-related injuries, property and equipment damage at the Project Site, as well as minimize risk to the public and third-party property. All contractors shall undertake loss control prevention practices according to those requirements set by Federal, State and local laws.

In the event of an accident, the contractor present at the Project Site should take action to assure that injured worker(s) or member(s) of the public are given immediate medical treatment. The Contractor or Subcontractor involved in the accident shall insure that all appropriate medical and claim forms are filed with the appropriate State Authorities and in accordance with the claim procedures developed for this project by SEWUP.

The party legally responsible for any loss or damage shall, to the extent of such responsibility, pay any deductible shown on the OCIP Insurance Documentation.

Section 2

2.0 Information Directory

2.1 Insurance Broker & Program Administrator

Keenan & Associates

SEWUP Department

Attn. Sandy Nottingham

2355 Crenshaw Blvd., Suite 200
Torrance CA 90501
(800) 654-8102 x2006
(310) 787-8838 Fax

Need Help?
Contact :
SEWUP Department

(800) 654-8102
(310) 787-8838 fax

2.2 Insurance Companies

Workers' Compensation	Zurich American Insurance Company
General Liability	Zurich American Insurance Company
Builder's Risk	Zurich American Insurance Company
Contractor's Pollution Liability	Steadfast Insurance Company

Insurance Company Contact Information

Have your Workers' Compensation Policy Number ready, which was issued to you by the SEWUP Administrator, when reporting a Workers' Compensation claim to Zurich at the number indicated below. **Always identify your company as being part of the SEWUP.**

Ambulance	911	
Employee Injury – First Report	877-928-4531	Zurich US
Property Damage – Third Parties	877-928-4531	Zurich US
Personal Injuries – Third Parties	877-928-4531	Zurich US

Section 3

3.0 OCIP Coverages

Description of Owner Controlled Insurance Program (OCIP) Coverages

The OCIP is for the benefit of the District and all Enrolled Contractors and/ or Subcontractors who have on-site employees. OCIP coverage applies only to Work performed under the contract at the Project Site specified by the District. All Contractors must provide their own insurance for Automobile Liability and off-site locations, labor, and operations. The following coverages are provided by the OCIP:

- Workers' Compensation and Employers Liability
- Commercial General Liability
- Excess Liability
- Builder's Risk
- Contractor's Pollution Liability

OCIP Certificates and Policies

Once an Eligible Contractor/Subcontractor enrolls into the SEWUP, Certificates of Insurance will be furnished by the Program Administrator for Workers' Compensation, General Liability, Contractor's Pollution Liability, and Builder's Risk coverages.

3.1 Workers' Compensation and Employer's Liability Insurance

Coverage A – Statutory Benefits

Liability imposed by the Workers' Compensation and/or Occupational Disease statute of the State of California or governmental authority having jurisdiction related to the work performed on the Project.

Coverage B – Employers Liability

$ 1,000,000 bodily injury per accident/employee

$ 1,000,000 bodily injury per disease/employee
$ 1,000,000 policy limit by disease

Contractor Deductible

None

3.2 Commercial General Liability Insurance

Primary Coverage: Limits for Bodily Injury and Property Damage

General Annual Aggregate- per Project	$ 10,000,000
Completed Operations Aggregate	$ 5,000,000
Each Occurrence	$ 5,000,000
Fire Legal Liability	$ 1,000,000
Personal & Advertising Injury	$ 1,000,000
Medical Payments (any one person)	$ 5,000

- Including Ten (10) Year Products and Completed Operations Extension beyond final acceptance of the entire project with a single non-reinstated aggregate limit.

Policy Form: "Occurrence" Form

Contractor Deductible:

None

3.3 Excess Liability Insurance

Limits of Liability Shared by All Enrolled Parties

Each Occurrence Limit	$25,000,000
Annual General Aggregate Limit	$25,000,000

- Policy follows form (provisions, coverages, exclusions, etc.) of underlying Commercial General Liability and Employer's Liability policy wording.
- Including Ten (10) Year Products and Completed Operations Extension beyond final acceptance of the entire project with a single non-reinstated aggregate limit.

Policy Form: "Occurrence" Form

Contractor Deductible:

None

3.4 Builders' Risk Insurance

Primary Coverage: The policy covers materials, supplies, equipment, fixtures, or machinery, which will become a permanent part of the building, structure, or Project at the Project site specified, limited to policy form and exclusions.

Builders Risk protects the insured's interest subject to the Estimated Maximum Value of the Project for any one loss or occurrence

Deductible:

A deductible of $10,000 - $25,000 ($50,000 on structural renovation work), which shall be determined by the type of construction, will apply to each occurrence. The deductible amount will be the responsibility of the contractor(s) suffering the loss or damage. Each affected contractor will be responsible for a proportionate share of the deductible. The deductible will not be reimbursed by the OCIP Insurance Program.

3.5 Contractor's Pollution Liability Insurance

Primary Coverage: Bodily Injury or Property Damage from a pollution event as defined within the policy form resulting from covered operations or completed operations.

Policy Limit: Each Loss/Total All Losses $25,000,000
Claim Expense (including Defense Costs) within policy limits.

Deductible:

$10,000 per Occurrence

The party legally responsible for any loss or damage shall to the extent of such responsibility pay the deductible.

Section 4

4.0 Contractor Requirements

Contractor OCIP Requirements & Instructions

4.1 Participation in the OCIP

Participation in the OCIP is mandatory but not automatic. Each Eligible Contractor/Subcontractor must comply with the following:

A. Contractor Eligibility, as defined below:

Eligible Contractor includes all Contractors/Subcontractors providing direct labor on the Project. Temporary labor services and leasing companies are to be treated as Eligible Contractors.

Ineligible Contractor includes, but is not limited to, consultants; suppliers who do not perform or do not subcontract installation; demolition that includes abatement and hazardous materials removal; vendors; materials dealers; guard services; non-construction janitorial services; and truckers, including trucking to the Project where delivery is the only scope of work performed. However, if contracted with an on-site installer, suppliers/vendors should be enrolled in the OCIP only for General Liability, as it pertains to the contractual relationship of the installer's on-site work. Any questions regarding a Contractor's status as "Eligible" or "Ineligible" should be referred to the Program Administrator.

All SEWUP forms can be found in Section 7.0 of this manual

B. Enrollment Compliance

An Eligible contractor is not enrolled until the Program Administrator receives and approves a completed *Contract Enrollment Form*, for each awarded contract, within ten (10) days of Notice of Award. Evidence of Insurance for work performed off-site is a requirement (see Section 4.1, C and D) and must be submitted with the completed *Contract Enrollment Form*. Any Contractor and/ or Subcontractor who enrolls in the OCIP after their start date will have

to provide a No-Known-Loss Letter to the Program Administrator, along with the enrollment documentation. Enrollment is not guaranteed until acceptance of the enrollment documentation by the insurance carrier. The Program Administrator will provide evidence of OCIP coverage to the Contractor/Subcontractor, as noted in Section 3.0 OCIP Coverages, OCIP Certificates and Policies.

C. Required Contractor-Provided Insurance Coverages

For any work under this contract, and until completion and final acceptance of the work by the District, the Contractors/Subcontractors shall, at their own expense, promptly furnish Certificates of Insurance to the Program Administrator evidencing Workers' Compensation & General Liability coverages for off-site locations, labor, and operations before commencing work on the Project Site. Automobile Liability Insurance must be maintained for both Project Site and off-site operations.

Furthermore, the policies shall provide not less than thirty (30) days prior written notice to the Program Administrator, of any material change in the insurance, cancellation, or non-renewal.

D. Required Contractor-Provided Certificates of Insurance

Certificates of Insurance evidencing Automobile Liability, Off-site Workers' Compensation and General Liability, and any other insurance coverage as required by contract, must be filed with the District and Program Administrator within ten (10) days of Notice of Award by all Contractors/Subcontractors and prior to commencement of on-site activities. All required insurance shall be maintained, without interruption, from the Notice to Proceed date, until the date of the final payment or expiration of any extended period. The Project Site must be identified on the Certificate of Insurance in the "Description of Operations/Locations /Vehicles/Special Items" section. The Certificates of Insurance should name the District as the Certificate Holder, c/o Statewide Educational Wrap Up Program, as specified below:

Certificate Holder:

San Mateo County Community College District
c/o Statewide Educational Wrap Up Program
2355 Crenshaw Blvd., Suite 200
Torrance, CA 90501

All Contractors/Subcontractors shall cooperate with, and require their Subcontractors to cooperate with, the District and the Program Administrator, in regards to the administration and operation of the OCIP. Each Contractor must include this document with their bid specifications to any and all Subcontractors.

4.2 Contractor's Compliance With Other Forms and Procedures

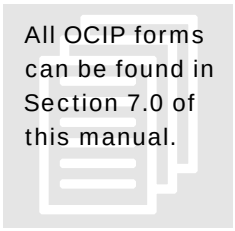
All Eligible Contractors/Subcontractors are required to complete and submit the following forms:

A. Payroll Reporting

1. Workers' Compensation Insurance Rating Bureau Requirements

Once an Eligible Contractor/Subcontractor is enrolled into the OCIP, the Program Administrator will issue a separate Workers' Compensation Policy. All Enrolled Contractors/Subcontractors will need to comply with the rules and regulations of the California Workers Compensation Insurance Rating Bureau (WCIRB).

2. Project Site Monthly Payroll Report



Project Site Monthly Payroll Reports must be submitted to the Program Administrator on a **monthly** basis, until the completion of the contract. This report must summarize the unburdened payroll by Workers' Compensation Class Code. Certified payroll is **not** a requirement of the OCIP and cannot be accepted. If the Project Site Monthly Payroll Report is not submitted to Program Administrator on a monthly basis, the Construction Manager and/or District can withhold payment until the report is received. Contractor agrees to keep and maintain accurate and classified records of their payroll for operations at the Project Site. This payroll information is submitted to the OCIP Insurance Carrier. At the end of each contract, a carrier audit may be performed using the reported payroll.

B. Contractor's Completion Notice

Contractor's Completion Notice must be submitted to the Program Administrator upon completion of work at the Project Site, which includes punch list items, but **not** warranty or service contract work. This form evidences all enrolled Contractors'/Subcontractors' actual start and completion dates, per each contract. This information is used to confirm that each Workers' Compensation Policy was issued with correct policy term dates, covering the Contractors/Subcontractors for the duration of their Work at the Project Site. This information is subsequently submitted to the WCIRB.

Section 5

5.0 Project Safety Expectations

Project Safety and Loss Control Procedures and Requirements

Non-compliance with the Project Safety and Loss Control Requirements is equivalent to non-compliance with any other contractual condition.

All Contractors and subcontractors of every tier must comply with the Project's Safety and Loss Control procedures and requirements.

Note

Potential bidders must recognize, and anticipate in their bids, the unique nature of construction at existing school sites, where there are numerous detailed regulations concerning student safety and community relations. Contractors are cautioned that the students will be continually observing, and learning from the workplace practices on the construction site.

SEWUP; therefore, has established the following additional safety requirements.

5.1 Safety Requirements Scope & Application

- The General or Prime Contractor shall assume overall responsibility for Project safety compliance.
- All Contractors/Subcontractors shall identify their contact person(s).
- Job specific Emergency Response Plans (with particular emphasis on access and egress routes) shall be developed and posted.
- If applicable, Contractors/Subcontractors shall follow District procedures for dealing with the media.
- Personal Protective Equipment shall be used in accordance with Cal/OSHA.
- No alcohol shall be allowed on construction Project Sites at any time.

- Smoking is prohibited on school grounds.

- Any Contractor/Subcontractor employee observed providing or selling cigarettes, other smoking materials or illegal substances shall be removed from the Project Site until further notice.

- All Contractors/Subcontractors, upon request by the District or the Program Administrator, shall agree to conduct and fund post-injury drug screening of their employees. Those employees failing the test shall be removed permanently from the Project Site.

- Contractors/Subcontractors shall take appropriate measures to control worksite access, i.e. keeping non-construction personnel away from construction activities. Appropriate measures include, but are not limited to, barriers and/or fencing. Contract specifications may specifically address this item.

- Contractors/Subcontractors shall be required to respond to any school complaints about objectionable levels of dust or noise and shall be required to provide the appropriate abatement as quickly as possible.

- Construction personnel cannot enter school grounds other than the Project Site, unless accompanied by District personnel; and they are allowed only 'incidental' contact with students. Violations of these requirements by any construction employee shall result in a mandatory background check of that employee, including fingerprinting, as required by state law.

- If a Contractor/Subcontractor fails to promptly correct an identified unsafe act or condition, the District, or its representative may have the condition corrected and bill the non-compliant Contractor/Subcontractor for the costs associated with the correction.

- Any Contractor/Subcontractor displaying, in the opinion of the General Contractor, Prime Contractor or SEWUP Senior Loss Control Consultant, a repeated disregard for safety can be removed from the Project Site.

- Each Contractor/Subcontractor shall have readily available the Injury and Illness Prevention Program, Hazard Communication Plan, Material Safety Data Sheets, Toolbox Safety Meetings, and documented safety inspections conducted by each Contractor/Subcontractor, as required by Cal/OSHA.

- Any type of personal radios, headsets, walkmans, I Pod's and CD players are not allowed on the Project Site.

- All Contractors/Subcontractors must attend the Pre-Construction Safety Meeting.

- No sexual reference or preference shall be permitted on any piece of clothing or hardhat. Any employee observed disregarding this policy shall be removed from the Project Site until further notice.

- All Contractor/Subcontractor employees shall park in their designated parking area. Any sticker attached to the employees' vehicle that displays any form of sexual preference or reference shall be removed prior to parking at the Project Site. Each employee shall provide his or her license plate number to the General or Prime Contractor. Any employee disregarding this policy shall be removed from the Project Site until further notice.

- All Contractors/Subcontractors shall control the break-time activities of the employees to assure the cleanup of all soda cans, food wrappers, plastic bottles, or food containers from the break area. Such areas shall be cleaned immediately after the break, and all waste placed in trash receptacles. No glass containers are permitted on the Project site.

- Theft or willful damage to any property of the District, student, or other Contractor/Subcontractor shall be prosecuted fully.

- No guns, switchblades, or knives with blades greater than two inches shall be allowed on the Project Site. Any employee disregarding this policy shall be removed from the Project Site until further notice.

- All Contractors/Subcontractors shall advise those non-English speaking employees, in their native language, either in a written format or via an interpreter, of these policies.

Section 6

6.0 Claims Reporting

Accident/Claims Reporting Procedures - Overview

The immediate reporting of all accidents or circumstances, which might lead to or involve a claim, is a requirement of the OCIP. When in doubt, refer all questions regarding the reporting of a claim to Keenan & Associates.

6.1 Workers' Compensation Claims Reporting Procedures

Accident Reporting

The Labor Code requires that an employee report any injury immediately to the employer. There are multitudes of circumstances when this is not followed when the employee reports the injury many days or weeks after the date. No matter when the injury occurred, there are several essential requirements for the employee to perform, once the injury has actually been reported.

The Labor Code provides for possible penalties to be assessed if the following time lines are not met:

- Provision of the Employee Claim Form, DWC-1, within one (1) working day of the employer's knowledge of a disability or injury beyond first aid. Each employer is responsible for providing this form to an injured employee.
- Provision of the Employer's Report of Injury, Form 5020, within five (5) of **knowledge** every occupational injury or illness which results in lost time beyond the date of the incident or requires medical treatment at a medical facility. In addition, every serious illness/injury or death must be reported immediately by telephone or fax to the nearest office of the California Division of Occupational Safety and Health.
- Provision of a benefit letter and/or disability check within fourteen (14) days of the first day of additional lost time after returning to work. This will be the responsibility of Zurich Insurance Company.

First Aid

Should an employee report a work injury or illness that is minor and does not require a doctor visit or time off from work, the supervisor should refer the employee to the nearest first aid treatment available at the site.

If the injury requires a doctor (or medical office) visit or involves lost time, please follow the procedures listed below.

Procedure for Work Injury Reporting

1. If the injury is serious, call 911 immediately for assistance!
2. Access the Workers' Compensation Claim Kit, sent to you by the Program Administrator, and follow the step-by-step directions.
3. Complete items #1, #9, #10, #11, #12 and #14 on the Employee Claim Form, DWC-1. Give the form to the employee. Should the employee fill out their portion of the form immediately, complete the remaining sections in the employer box and follow the directions located on the bottom of the form for dispersal of copies. Should the employee not be available for hand delivery, mail the DWC-1 to the employee at their home address.

   This procedure must be completed within one (1) working day of the employer's knowledge of the injury.
4. Give employee Facts for Injured Workers pamphlet.
5. Call 877-928-4531 telephone report hotline to report the injury. Have your SEWUP Workers' Compensation Policy Number ready and identify your company as being part of the SEWUP.
6. Direct the injured worker to any of the medical facilities listed in the Claims Kit. Make sure to give the employee the "Medical Referral Form".
7. When the employee turns in the Employee Claim Form, DWC-1, immediately complete the employer section and follow directions at the bottom of the form for dispersal of copies.

An Employee Claim Form must be given to any employee who requests one within one working date regardless of whether you believe a job related injury has occurred.

6.2 General Liability Claim Reporting Procedures

Once aware of a third party liability claim or property loss, complete the attached loss report and submit it directly to Zurich US Construction Claims Department. Call the (877) 928-4531 claim report hotline to report the loss.

Forward a copy to Keenan & Associates at (310) 787-8838 to the attention of the SEWUP Department.

6.3 Builder's Risk Claim Reporting Procedures

Once aware of a Builder's Risk claim, complete the Property Loss Report and submit it directly to Keenan & Associates-SEWUP Department, attention Claims by mail or fax to (310) 787-8838.

6.4 Contractor's Pollution Liability Claim Reporting Procedures

Once aware of a Contractor's Pollution claim, complete the Property Loss Report and submit it directly to Keenan & Associates-SEWUP Department, attention Claims by mail or fax to (310) 787-8838.

6.5 Instructions and Procedures – Litigation Papers, Legal Documents, etc.

If your firm is served with a lawsuit arising out of your involvement with the School District's Project, please forward to the Program Administrator's Insurance Carrier and wait for specific instruction upon receipt.

If receipt of litigation papers or legal documents are your first notice of a claim, please call the SEWUP Department at Keenan & Associates at (800) 654-8102 to report the claim.

Section 7

7.0 Required Project Forms

Contract Enrollment Form

Project Site Monthly Payroll Report

Contractor's Notice Of Completion

First Report Of Injury (5020)

Worker's Compensation Claim Form (DWC-1)

SEWUP Liability and Property Loss Report

ACCORD Property Loss Notice

STATEWIDE EDUCATIONAL WRAP UP PROGRAM

OWNER CONTRC ANCE PROGRAM

SEWUP

STATEWIDE EDUCATIONAL WRAP UP PROGRAM

CONTRACTOR ENROLLMENT FORM

District Name: San Mateo County Community College District

Project Name: _____

Contractor Information

CONTRACTOR/SUBCONTRACTOR (LEGAL NAME): _____

IF YOU ARE A SUBSIDIARY AND / OR DIVISION OF ANOTHER COMPANY, PLEASE INDICATE THE NAME ON FILE WITH THE BUREAU:

_____

ADDRESS: _____

CITY: _____ State: _____ Zip: _____

NAME & TITLE OF PERSON(S) TO CONTACT: _____ E-Mail Address: _____

PHONE NUMBER: ( ) _____ FAX: _____

CONTRACTOR LICENSE #: _____ FEDERAL ID #: _____

ENTITY:

☐ Sole Proprietorship: ☐ PARTNERSHIP: ☐ Corp: ☐ OTHER: ☐

Payroll/Accounting Contact (If Other Than Above): _____

PHONE: ( ) _____ FAX: ( ) _____ E-MAIL ADDRESS: _____

Contract Details

YOUR STATUS ON THIS PROJECT:

☐ (A) GENERAL/PRIME CONTRACTOR ☐ (b) Subcontractor

☐ (c) Tier/Subcontractor ☐ (D) OTHER _____

IF YOU CHECKED (B), (C) OR (D) ABOVE, GIVE NAME OF THE CONTRACTOR FOR WHOM YOU ARE UNDER CONTRACT WITH: _____

BID PACKAGE # (IF APPLICABLE): _____ TOTAL CONTRACT AMOUNT: $ _____

CONTRACT AWARD DATE: _____ CONTRACT AMOUNT FOR SELF $ _____

ESTIMATED START DATE*: _____ ESTIMATED COMPLETION DATE: _____

*This will be the effective date of your OCIP coverage, unless notified otherwise

DESCRIPTION OF WORK PERFORMED: _____

_____

FOR THIS PROJECT, WILL YOU BE DOING OFF-SITE WORK? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE? _____

Please Fax or Mail To:

Keenan & Associates, 2355 Crenshaw Blvd., Ste. #200, Torrance, CA 90501
Attn: SEWUP Department, Phone (310) 212-3344, Fax (310) 787-8838

Keenan & Associates

STATEWIDE EDUCATIONAL WRAP UP PROGRAM

OWNER CONTROLLED INSURANCE PROGRAM

Project **Contractor Name:**

Description of Work	WC Class Code	On-Site Man-hours	On-Site Straight Time Payroll
Example: Carpenter <$22/hour	5403	160	$3,040

Please Fax or Mail To:

Keenan & Associates, 2355 Crenshaw Blvd., Ste. #200, Torrance, CA 90501
Attn: SEWUP Department, Phone (310) 212-3344, Fax (310) 787-8838

STATEWIDE EDUCATIONAL WRAP UP PROGRAM

OWNER CONTROLLED INSURANCE PROGRAM

Project Name: ____________________ **Contractor Name:** ____________________

Expected Subcontractors: If any work is to be subcontracted under this Contract, please complete the following information for each Subcontractor. Use additional pages, if necessary.

Company Name: ____________________ Contact Person: ____________________
Address: ____________________
City/State/Zip Code: ____________________
Phone: ____________ Fax: ____________ E Mail: ____________
Scope of Work: ____________________
Contractor License ____________________ Contract Value: ____________________
Est. Start Date: ____________________ Est. Completion Date: ____________________

Company Name: ____________________ Contact Person: ____________________
Address: ____________________
City/State/Zip Code: ____________________
Phone: ____________ Fax: ____________ E Mail: ____________
Scope of Work: ____________________
Contractor License ____________________ Contract Value: ____________________
Est. Start Date: ____________________ Est. Completion Date: ____________________

Company Name: ____________________ Contact Person: ____________________
Address: ____________________
City/State/Zip Code: ____________________
Phone: ____________ Fax: ____________ E Mail: ____________
Scope of Work: ____________________
Contractor License ____________________ Contract Value: ____________________
Est. Start Date: ____________________ Est. Completion Date: ____________________

Company Name: ____________________ Contact Person: ____________________
Address: ____________________
City/State/Zip Code: ____________________
Phone: ____________ Fax: ____________ E Mail: ____________
Scope of Work: ____________________
Contractor License ____________________ Contract Value: ____________________
Est. Start Date: EST. COMPLETION DATE:

Please Fax or Mail To:

Keenan & Associates, 2355 Crenshaw Blvd., Ste. #200, Torrance, CA 90501
Attn: SEWUP Department, Phone (310) 212-3344, Fax (310) 787-8838

STATEWIDE EDUCATIONAL WRAP UP PROGRAM

OWNER CONTROLLED INSURANCE PROGRAM

I DECLARE UNDER PENALTY OF PERJURY, UNDER THE LAWS OF THE STATE OF CALIFORNIA, THAT THE INFORMATION CONTAINED IN THIS DOCUMENT IS TRUE AND CORRECT. I HEREBY UNDERSTAND THAT ENROLLMENT IS CONTINGENT UPON RECEIPT AND ACCEPTANCE OF THIS FORM. SHOULD I SUBMIT AN INCOMPLETE FORM, KEENAN'S SEWUP DEPARTMENT WILL CONTACT ME AND MY FIRM WILL NOT BE ENROLLED UNTIL I PROVIDE ALL NECESSARY INFORMATION IN ITS ENTIRETY.

PRINT NAME: _____ TITLE: _____

Signature: _____ DATE: _____

Attach copies of your Workers' Compensation & General Liability Declarations pages, including proof of rates from your current policies. Submit a copy of your Certificate of Insurance evidencing WC, GL, and Auto Liability coverage. Compliance with this request will expedite your enrollment.

Please Fax or Mail To:

Keenan & Associates, 2355 Crenshaw Blvd., Ste. #200, Torrance, CA 90501
Attn: SEWUP Department, Phone (310) 212-3344, Fax (310) 787-8838

STATEWIDE EDUCATIONAL WRAP UP PROGRAM

PROJECT SITE MONTHLY PAYROLL REPORT
DUE ON THE 10TH OF EACH MONTH (FOR PREVIOUS MONTH LABOR)

District Name: San Mateo County Community College District Bid Pkg. #: _____

Project Name: _____ REPORT # _____

(For your Firm's use)

Reporting Month: _____ Example: February 2006

Company Name: _____ Dba Name: _____

Under Contract With: _____ SEWUP Site Code*: _____

*(Internal Use Only) To be assigned by the SEWUP Administrator.

Workers' Compensation Class Code	Work Description	Total Monthly Man-hours	Payroll*
	TOTALS	$	

I CERTIFY THAT THE INFORMATION REPORTED ABOVE IS TRUE AND ACCURATE. NOT REPORTING ACCURATE PAYROLL INFORMATION COULD AFFECT YOUR EXMOD - EXPERIENCE MODIFICATION RATING WITH THE WORKERS' COMPENSATION INSURANCE RATING BUREAU (WCIRB).

Signature: _____ Title: _____

Print Name: _____ Date: _____

*Do not include overtime wage rates, use straight time wage rates only, i.e., employee earns $20/hr. and works 10 hours in one day, you would report $200.00 ($20.00 x 10). If paid to third party (union) - exclude. If taxable to employee, then it is reported to WCIRB.

Return Completed Form Via Fax To:
Keenan & Associates, 2355 Crenshaw Blvd., Ste. #200, Torrance, CA 90501
Attn: SEWUP Department, Phone (310) 212-3344, Fax (310) 787-8838

Contractor's Completion Notice

District Name: San Mateo County Community College District

Project Name: _____

IMPORTANT NOTIFICATION – PLEASE READ

Contractor or Subcontractor agrees to complete this form and return to Keenan & Associates upon completion or termination of work activities under this contract. Please include, with this form, any supporting documents for final contact value (if different from initial contract value).

Initial Contract Value: _____

Final Contract Value: _____

Last Day on Site*: _____

**This would include work performed on final closeout or punch-list items and should not include warranty work.*

Contractor/Subcontractor Legal Name: _____

Contractor/Subcontractor dba Name: _____

Contractor License Number: _____

Address: _____

Representative's Name (Print): _____ Title: _____

Signature: _____ Date: _____

Fax or Mail Completed Form To:
Keenan & Associates, 2355 Crenshaw Blvd., Ste. #200, Torrance, CA 90501
Attn: SEWUP Department
Phone (310) 212-3344, Fax (310) 787-8838

District Name: SAN MATEO COUNTY CCD

Project Name:

State of California

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

PLEASE COMPLETE (TYPE, IF POSSIBLE). MAIL TWO COPIES TO:

OSHA CASE NO.

☐ FATALITY

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

NOTICE: California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious illness/injury or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health

EMPLOYER

1. FIRM NAME | 1A. POLICY NUMBER | DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, City, ZIP) | 2A. PHONE NUMBER | Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, City, ZIP) | 3A. LOCATION CODE | Districtship
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc. | 5. STATE UNEMPLOYMENT INSURANCE ACCT NUMBER | Industry
6. TYPE OF EMPLOYER ☐ PRIVATE ☐ STATE ☐ CITY ☐ COUNTY ☐ SCHOOL DIST. ☐ OTHER GOV. – SPECIFY _____ | Occupation

EMPLOYEE

7. EMPLOYEE NAME | 8. SOCIAL SECURITY NUMBER | 9. DATE OF BIRTH (mm dd yy) | Sex
10 HOME ADDRESS (Number and Street, City, ZIP) | 10A PHONE NUMBER | Age
11. SEX ☐ MALE ☐ FEMALE | 12. OCCUPATION (Regular job title – NO initials, abbreviations or numbers) | 13 DATE OF HIRE (mm dd yy) | Daily Hours
14 EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours | 14A EMPLOYMENT STATUS (check applicable status at time of injury) ___ regular full-time ___ part time ___ temporary ___ seasonal | 14B Under what class code of your policy were wages assigned | Days per Week
15 GROSS WAGES / SALARY $_____ PER _____ | 16 OTHER PAYMENTS NOT REPORTED AS WAGES/Salary (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES $_____ PER _____ ☐ NO | | Weekly Hours

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET OF ILLNESS (mm dd yy) | 18 TIME INJURY ILLNESS OCCURRED A.M. P.M. | 19 TIME EMPLOYEE BEGAN WORK A.M. P.M. | 20. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy) | Weekly Wage
21 UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY ☐ YES ☐ NO | 22. DATE LAST WORKED (mm dd yy) | 23. DATE RETRUNED TO WORK (mm dd yy) | 24. IF STILL OFF WORK, CHECK THIS BOX ☐ | County
25. PAID FULL WAGES FOR DAY OF INJURY OR LAST DAY WORKED ☐ YES ☐ NO | 26. SALARY BEING CONT'D? ☐ YES ☐ NO | 27. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (mm dd yy) | 28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy) | Nature of Injury
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available , e.g., second degree burns on right arm, tendonitis of left elbow, lead poisoning | | | | Part of Body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number and Street, City) | 30A COUNTY | 30B. ON EMPLOYER'S PREMISES ☐ YES ☐ NO | | Source
31 DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g. shipping department, machine shop. | 32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO | | | Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold | | | | Sec. Source
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal forms, loading boxes into truck | | | | Extent of Injury
35 HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS,, e.g., worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld and burned right hand. USE SEPARATE SHEET IF NECESSARY | | | | |
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP) | 36A. PHONE NUMBER | | | |
37 IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP) | 37A. PHONE NUMBER | | | |

COMPLETED BY (type or print)	SIGNATURE	TITLE	DATE

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación para Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Attached is the form for filing a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If required you will be notified by the claims administrator, who is responsible for handling your claim, about your eligibility for benefits.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Your employer will then complete the "Employer" section, give you a dated copy, keep one copy and send one to the claims administrator. Benefits can't start until the claims administrator knows of the injury, so complete the form as soon as possible.

Medical Care: Your claims administrator will pay all reasonable and necessary medical care for your work injury or illness. Medical benefits may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, and medicines. Your claims administrator will pay the costs directly so you should never see a bill. For injuries occurring on or after 1/1/04, there is a limit on some medical services.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness. Generally your employer selects the PTP you will see for the first 30 days, however, in specified conditions, you may be treated by your predesignated doctor. If a doctor says you still need treatment after 30 days, you may be able to switch to the doctor of your choice. Special rules apply if your employer offers a Health Care Organization (HCO) or after 1/1/05, has a medical provider network. Contact your employer for more information. If your employer has not put up a poster describing your rights to workers' compensation, you may choose your own doctor immediately.

Within one working day after an employee files a claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide treatment until the date that liability for the claim is accepted or rejected. Until the date the claim is accepted or rejected, liability for medical treatment shall be limited to ten thousand dollars ($10,000).

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you will receive temporary disability payments. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Si Ud. se lesiona o se enferma, ya sea física o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación para trabajadores. Se adjunta el formulario para presentar un reclamo de compensación para trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran, dependiendo de la índole de su reclamo. Si se requiere, el/la administrador(a) de reclamos, quien es responsable del manejo de su reclamo, le notificará a usted, lo referente a su elegibilidad para beneficios.

Para presentar un reclamo, complete la sección del formulario designada para el "Empleado", guarde una copia, y déle el resto a su empleador. Entonces, su empleador completará la sección designada para el "Empleador", le dará a Ud. una copia fechada, guardará una copia, y enviará una al/a la administrador(a) de reclamos. Los beneficios no pueden comenzar hasta, que el/la administrador(a) de reclamos se entere de la lesión, así que complete el formulario lo antes posible.

Atención Médica: Su administrador(a) de reclamos pagará toda la atención médica razonable y necesaria, para su lesión o enfermedad relacionada con el trabajo. Es posible que los beneficios médicos incluyan el tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio y las medicinas. Su administrador(a) de reclamos pagará directamente los costos, de manera que usted nunca verá un cobro. Para lesiones que ocurren en o después de 1/1/04, hay un límite de visitas para ciertos servicios médicos.

El Médico Primario que le Atiende-*Primary Treating Physician PTP* es el médico con toda la responsabilidad para dar el tratamiento para su lesión o enfermedad. Generalmente, su empleador selecciona al *PTP* que Ud. verá durante los primeros 30 días. Sin embargo, en condiciones específicas, es posible que usted pueda ser tratado por su médico pre-designado. Si el doctor dice que usted aún necesita tratamiento después de 30 días, es posible que Ud. pueda cambiar al médico de su preferencia. Hay reglas especiales que son aplicables cuando su empleador ofrece una Organización del Cuidado Médico (HCO) o depués de 1/1/05 tiene un Sistema de Proveedores de Atención Médica. Hable con su empleador para más información. Si su empleador no ha colocado un poster describiendo sus derechos para la compensación para trabajadores, Ud. puede seleccionar a su propio médico inmediatamente.

El empleador autorizará todo tratamiento médico consistente con las directivas de tratamiento applicables a la lesión o enfermedad, durante el primer día laboral después que el empleado efectúa un reclamo para beneficios de compensación, y continuará proveyendo este tratamiento hasta la fecha en que el reclamo sea aceptado o rechazado. Hasta la fecha en que el reclamo sea aceptado o rechazado, el tratamiento médico será limitado a diez mil dólares ($10,000).

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación para los trabajadores, sus expedientes médicos no tendrán la misma privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un(a) juez de compensación para trabajadores posiblemente decida qué expedientes se revelarán. Si Ud. solicita privacidad, es posible que el/la juez "selle" (mantenga privados) ciertos expedientes médicos.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. recibirá pagos por incapacidad temporal. Es posible que estos pagos cambien o paren, cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación para Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

Return to Work: To help you to return to work as soon as possible, you should actively communicate with your treating doctor, claims administrator, and employer about the kinds of work you can do while recovering. They may coordinate efforts to return you to modified duty or other work that is medically appropriate. This modified or other duty may be temporary or may be extended depending on the nature of your injury or illness.

Payment for Permanent Disability: If a doctor says your injury or illness results in a permanent disability, you may receive additional payments. The amount will depend on the type of injury, your age, occupation, and date of injury.

Vocational Rehabilitation (VR): If a doctor says your injury or illness prevents you from returning to the same type of job and your employer doesn't offer modified or alternative work, you may qualify for VR. If you qualify, your claims administrator will pay the costs, up to a maximum set by state law. VR is a benefit for injuries that occurred prior to 2004.

Supplemental Job Displacement Benefit (SJDB): If you do not return to work within 60 days after your temporary disability ends, and your employer does not offer modified or alternative work, you may qualify for a nontransferable voucher payable to a school for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law based on your percentage of permanent disability. SJDB is a benefit for injuries occurring on or after 1/1/04.

Death Benefits: If the injury or illness causes death, payments may be made to relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) benefits. Call State Employment Development Department at (800) 480-3287.

You can obtain free information from an information and assistance officer of the State Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. You may also go to the DWC web site at **www.dir.ca.gov**. Link to Workers' Compensation.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at **www.californiaspecialist.org**.

impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estatales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado(a) de noche, o no pueda trabajar durante más de 14 días.

Regreso al Trabajo: Para ayudarle a regresar a trabajar lo antes posible, Ud. debe comunicarse de manera activa con el médico que le atienda, el/la administrador(a) de reclamos y el empleador, con respecto a las clases de trabajo que Ud. puede hacer mientras se recupera. Es posible que ellos coordinen esfuerzos para regresarle a un trabajo modificado, o a otro trabajo, que sea apropiado desde el punto de vista médico. Este trabajo modificado, u otro trabajo, podría extenderse o no temporalmente, dependiendo de la índole de su lesión o enfermedad.

Pago por Incapacidad Permanente: Si el doctor dice que su lesión o enfermedad resulta en una incapacidad permanente, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, su edad, su ocupación y la fecha de la lesión.

Rehabilitación Vocacional: Si el doctor dice que su lesión o enfermedad no le permite regresar a la misma clase de trabajo, y su empleador no le ofrece trabajo modificado o alterno, es posible que usted reúna los requisitos para rehabilitación vocacional. Si Ud. reúne los requisitos, su administrador(a) de reclamos pagará los costos, hasta un máximo establecido por las leyes estatales. Este es un beneficio para lesiones que ocurrieron antes de 2004.

Beneficio Suplementario por Desplazamiento de Trabajo: Si Ud. no vuelve al trabajo en un plazo de 60 días después que los pagos por incapcidad temporal terminan, y su empleador no ofrece un trabajo modificado o alterno, es posible que usted reúne los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo entrenamiento y/o mejorar su habilidad. Si Ud. reúne los requisitios, el administrador(a) de reclamos pagará los costos hasta un máximo establecido por las leyes estatales basado en su porcentaje del incapicidad permanente. Este es un beneficio para lesiones que ocurren en o después de 1/1/04.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a los parientes o a las personas que vivan en el hogar, que dependían económicamente del/de la trabajador(a) difunto(a).

Es ilegal que su empleador le castigue o despida, por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por atestiguar en el caso de compensación para trabajadores de otra persona. (El Codigo Laboral sección 132a). Si es probado, puede ser que usted reciba pagos por perdida de sueldos, reposición del trabajo, aumento de beneficios, y gastos hasta un límite establecido por el estado.

Ud. tiene derecho a estar en desacuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su administrador(a) de reclamos, para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios de Seguro Estatal de Incapacidad (SDI). Llame al Departamento Estatal del Desarrollo del Empleo (EDD) al (800) 480-3287.

Ud. puede obtener información gratis, de un oficial de información y asistencia, de la División estatal de Compensación al Trabajador *(Division of Workers' Compensation – DWC)*, o puede escuchar información grabada, así como una lista de oficinas locales, llamando al **(800) 736-7401**. Ud. también puede ir al sitio electrónico en el Internet de la DWC en **www.dir.ca.gov**. Enlácese a la sección de Compensación para Trabajadores.

Ud. puede consultar con un(a) abogado(a). La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un(a) abogado(a), sus honorarios se tomarán de sus beneficios. Para obtener nombres de abogados de compensación para trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, ó vaya a su sitio electrónico en el Internet en **www.californiaspecialist.org**.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

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

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
   _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
   _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

7/1/04 Rev.

District Name: SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Project Name:

SEW UP LIABILITY & PROPERTY LOSS REPORT

LIABILITY LOSS ☐
PROPERTY LOSS ☐

SUBMIT TO:
KEENAN & ASSOCIATES
SEWUP Department
2355 CRENSHAW BOULEVARD, SUITE 200
TORRANCE, CA 90501
TELEPHONE: (310) 212-0363 (800) 654-8102
FAX: (310) 787-8838

CONFIDENTIAL - ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE
This form is a confidential, internal, document; its contents are not to be shared or copied for any persons who are not school district employees and/or their legal representatives.

CONFIDENTIAL ACCIDENT REPORT

IN CASE OF SERIOUS INJURIES A TELEPHONE REPORT IS TO BE MADE IMMEDIATELY

DATE OF REPORT:

NOTE: The employee either witnessing the accident or supervising at the time should complete and submit this form within 24 hours. Please type or print using ball point pen.

LIABILITY LOSS NOTICE

NAME OF CONTRACTOR 1	PROJECT NAME & NUMBER 2
ADDRESS OF PROJECT	

NAME OF INJURED PERSON (LAST, FIRST, M.I.) 3	AGE	TELEPHONE NUMBER OF INJURED PERSON ( )

IS INJURED PERSON A MINOR ☐ NO ☐ YES	NAME OF PARENT OR LEGAL GUARDIAN

ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE AND ZIP CODE)
4

WHERE DID ACCIDENT OCCUR 5	DATE (MONTH/DAY/YEAR)	TIME ☐ A.M. ☐ P.M.

DESCRIBE HOW ACCIDENT OCCURRED (USE FACTS ONLY; EXCLUDE OPINIONS AND/OR ASSSUMPTIONS)
6

NAME OF WITNESS(ES) 7	ADDRESS

FIRST AID PROCEDURES USED 8	NAME OF PERSON WHO ADMINISTERED FIRST AID

DISPOSITION OF INJURED AFTER ACCIDENT
9
☐ Home ☐ Doctor ☐ Hospital

REMARKS
10

PROPERTY LOSS NOTICE

LOCATION OF LOSS
11

KIND OF LOSS:
12
☐ FIRE ☐ THEFT ☐ VANDALISM ☐ WATER ☐ WIND ☐ OTHER

POLICE & FIRE DEPARTMENT REPORT NO. 13	
POSSIBLE AMOUNT OF LOSS 14	
DESCRIPTION 15	

NAME OF PERSON COMPLETING REPORT 16	NAME OF FIRM	TELEPHONE NUMBER OF PERSON ( )

District Name: _____

Project Name: _____

ACORD™ PROPERTY LOSS NOTICE

DATE

PRODUCER	PHONE (A/C, No, Ext):	MISCELLANEOUS INFO (Site & location code)	DATE OF LOSS AND TIME	PREVIOUSLY REPORTED
			☐ AM ☐ PM	☐ YES ☐ NO

CODE:	SUB CODE:
AGENCY CUSTOMER ID	

POLICY TYPE	COMPANY AND POLICY NUMBER	NAIC CODE	POLICY DATES
PROP/ HOME	CO:		EFF:
	POL:		EXP:
FLOOD	CO:		EFF:
	POL:		EXP:
WIND	CO:		EFF:
	POL:		EXP:

INSURED

NAME AND ADDRESS OF INSURED	DATE OF BIRTH
	SOC SEC # OR FEIN:
RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)
NAME AND ADDRESS OF SPOUSE (IF APPLICABLE)	DATE OF BIRTH
	SOC SEC # OR FEIN:

CONTACT

☐ CONTACT INSURED

NAME AND ADDRESS OF INSURED		
	RESIDENCE PHONE (A/C, No)	BUSINESS PHONE (A/C, No, Ext)
	WHERE TO CONTACT	WHEN TO CONTACT

LOSS

LOCATION OF LOSS	POLICE OR FIRE DEPT TO WHICH REPORTED

KIND OF LOSS: ☐ FIRE ☐ LIGHTNING ☐ FLOOD ☐ OTHER (explain) ☐ THEFT ☐ HAIL ☐ WIND

PROBABLE AMOUNT ENTIRE LOSS

DESCRIPTION OF LOSS & DAMAGE (Use separate sheet, if necessary)

POLICY INFORMATION

MORTGAGEE

☐ NO MORTGAGEE

HOMEOWNER POLICIES SECTION 1 ONLY (Complete for coverages A, B, C, D & additional coverages. For Homeowners Section II Liability Losses, use ACORD 3.)

A. DWELLING	B. OTHER STRUCTURES	C. PERSONAL PROPERTY	D. LOSS OF USE	DEDUCTIBLES	DESCRIBE ADDITIONAL COVERAGES PROVIDED
					ON

☐ COVERAGE A. EXCLUDES WIND

SUBJECT TO FORMS (Insert form numbers and edition dates, special deductibles)

FIRE, ALLIED LINES & MULTI-PERIL POLICIES (Complete only those items involved in loss)

ITEM	SUBJECT OF INSURANCE	AMOUNT	% COINS	DEDUCTIBLE	COVERAGE AND/OR DESCRIPTION OF PROPERTY INSURED
	☐ BLDG ☐ CNTS				
	☐ BLDG ☐ CNTS				
	☐ BLDG ☐ CNTS				

SUBJECT TO FORMS (Insert form numbers and edition dates, special deductibles)

FLOOD POLICY	BUILDING:	DEDUCTIBLE:	ZONE	☐ PRE FIRM ☐ POST FIRM	DIFF IN ELEV	FORM TYPE	☐ GENERAL ☐ DWELLING	☐ CONDO
	CONTENTS:	DEDUCTIBLE:						

WIND POLICY	BUILDING	DEDUCTIBLE	CONTENTS	ZONE	FORM TYPE	☐ GENERAL ☐ DWELLING	☐ CONDO

REMARKS/OTHER INSURANCE (List companies, policy numbers, coverages & policy amounts)/NY ONLY: PREVIOUS ADDRESS OF INSURED & WIFE'S MAIDEN NAME

CAT #	FICO #	ADJUSTER ASSIGNED	ADJUSTER #	DATE ASSIGNED

REPORTED BY	REPORTED TO	SIGNATURE OF INSURED	SIGNATURE OF PRODUCER

Applicable in Arizona

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

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

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

Applicable in California

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in Colorado

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

Applicable in Florida and Idaho

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

* In Florida - Third Degree Felony

Applicable in Hawaii

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

Applicable in Indiana

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

Applicable in Minnesota

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

Applicable in Nevada

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

Applicable in New Hampshire

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

Applicable in Ohio

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

Applicable in Oklahoma

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