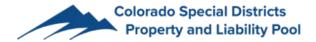


Workers' Compensation Coverage Application

District Information

District Legal Name:				
Federal Employer Identification Number (FEIN):			
Is your district currently a member of the	Special District Ass	sociation of Colorado?	Yes	No
Physical Address:				
Contact Information				
Workers' Compensation Contact:		Position/	Title:	
Workers' Compensation Claim Contact:		Position/	Title:	
Phone: F	ax:	Email:		
Does your district have a Management Co. If yes, please provide the information below: Y	ompany? es No	Does your district have an		
Management Company:		Insurance Agency:		
Contact:		Insurance Agent:		
Address:		Address:		
City, State ZIP:		City, State ZIP:		
Phone:		Phone:		
Fax:		Fax:		
Email:		Email:		
Board Information				
Number of board members:		Colorado law requires workers' o		
Total annual board stipend budgeted:		unless granted an exclusion pur	suant to C.R.S. section 8	3-40-202(1)(a)(I)(B)
Does any board member perform non-cle If yes, please provide a detailed job description and the es		f service:	Yes	No
Supplemental Information				
Does the district participate in Colorado's		ntainment Program?	Yes □	No □
If you attach a convert the district's Cost Containment Co.	tificato			

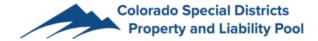


Workers' Compensation Coverage Application

Supplemental Information (cont.)

Does the district want an optional claim deductible quote? If yes, choose one or more of the following deductible amounts for the quote(s):					Yes No	
\square \$500 \square \$1,000 \square \$1,500 \square \$2,00		\$5,000				
Has NCCI calculated an experience modifier for the district for the current policy year? If yes, attach a copy of the most recent experience rating worksheet.					Yes	No
Provide a description of the nature of the	e district's busines	ss operation	s:			
·		•				
Employee Information						
Please enter information for all district en	nnlovees and volu	inteers Unc	ler Ioh Scone	groun empl	ovees by the t	type of wor
that they perform for the district, e.g., cl	•		•	z, group citipit	byces by the	.ypc or wor
			ber of	*No. of	Estimated	l Annual
Job Scope		full-time	oyees part-time	Volunteers	Payroll	
		jun-time	purt-time			
Estimated total annual hours of work:						
*Only include those volunteers for whom	the district intend	ds to provide	e Workers' C	ompensation	Coverage.	
om, medac mose volumeers for union.	the district meen	as to provide	o Workers C		eoverage.	
A - P- C detects						
Application completed by:						
Print Name	Signature				Date Signed	
Quote needed by:						
Date						

Return signed application to csdpool@mcgriff.com.



Workers' Compensation Coverage Application Concentration of Risk Form

District Legal Name:					Date:	
LOCATION NAME	PHYSICAL ADDRESS	CITY	COUNTY	ZIP	NO. OF FTE*	NO. OF STORIES

^{*}FTE stands for full-time equivalent, which is the total number of hours worked annually by all employees divided by 2,080. For example, a mixture of full-time and part-time employees at one location work a total of 8,320 hours in a year; this is equivalent to four (4) full-time employees, i.e., 8,320 hours worked divided by 2,080 equals four (4).

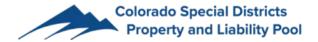


Workers' Compensation Coverage Application Best Practices Survey

Members of the Colorado Special Districts Property and Liability Pool can use the Best Practices Survey to evaluate their level of implementation of best practices for managing workers' compensation risk.

Please complete this survey to help us understand the district's safety and loss prevention management. We may reduce your contribution costs based on whether the district maintains satisfactory risk management procedures.

1 = not implemented 5 = fully implemented* LOSS CONTROL 3 4 1 1. Job Safety Analysis (all tasks, all employees) 2. Personal Protective Equipment Program 3. Safety Awareness and Loss Prevention Training 4. Hazard Communications and Safety Data Sheets are updated regularly 5. Safety Policy Manual is updated regularly **CLAIMS** 5 3 6. Claims Management and Accident Investigation Procedures 7. **Drug and Alcohol Testing Program** 8. **Designation of Four Medical Providers** П 9. Early Return to Work Program (for employees and volunteers) **OTHER** 1 2 3 4 10. Compliance with the Americans with Disabilities Act (ADA) 11. Employee Assistance Program (EAP) 12. **Employment Related Practices** 13. Handling Workplace Violence 14. All premises are free of hazards to visitors and employees (duty to inspect and correct) 15. Claims, incidents, and near-misses are investigated and reviewed to prevent recurrence 16. Safety Committee meets regularly **17.** Volunteer Policy (only if the district has covered volunteers) 18. Safety Rules are posted 19. Required State Notices are posted Full implementation means that the district maintains a written policy and procedure manual that is available to the district's directors and employees and that has been approved by legal counsel. Application completed by: **Print Name** Signature **Date Signed**



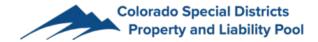
Workers' Compensation Coverage Application General Information Questionnaire

	District Legal Name:		
If you	answer "yes" to any of the following questions, please provide a detailed explanation via email.		
DIST	RICT INFORMATION	YES	NO
1.	Has any prior coverage been declined, cancelled, or non-renewed within the past three years?		
2.	Is the district engaged in any other type of business beyond its primary operation?		
3.	Do the district's operations involve storing, treating, discharging, applying, disposing of, or transporting hazardous materials, e.g., landfills, waste, fuel tanks, chemicals?		
4.	Does the district provide any group transportation?		
5.	Does the district own, operate, or lease aircraft?		
6.	Does the district own, operate, or lease watercraft?		
7.	Does the district hire subcontractors? If yes, has the district obtained Certificates of Insurance from each subcontractor?		
8.	Does the district or any employee of the district participate in training exercises with SWAT or a similar tactical-type program?		
EMP	PLOYEE INFORMATION	YES	NO
9.	Does the district use any volunteer or donated labor?		
10.	Does the district lease employees to or from other employers?		
11.	Is there an interchange of labor with any other business entity or subsidiary?		
12.	Do any district employees predominantly work from home?		
13.	Do any district employees travel outside of Colorado on official district business? If yes, under what circumstances?		
14.	Do any district employees perform work on barges, vessels, docks, or overwater bridges?		
15.	Do any district employees perform work underground or 15 feet or higher above the ground?		
16.	Does the district hire employees under age 18?		
17.	Does the district sponsor sporting events for its employees?		
18.	Does the district allow any employees to carry a weapon of any kind, including firearms?		
Applid	cation completed by:		
Print Na	me Signature Date Signed		



Workers' Compensation Coverage Application Supplemental Vehicle Application

Dis	trict Leg	gal Name:		Date:	
1.	How m	any vehicles does the d	istrict own?		
		Ambulances	Fire trucks		
		Passenger vehicles	Tractors		
		Van and trucks	Maintenance-type vehicles (e.g., lawnmowers)	
		Buses	Other vehicles		
2. 4.		•	strict employ? 3. How many vehicles does t portation of employees to or from the workplace?	he district lease Yes	? No
٦.		·		163	NO
5.	Describ	oe the district's use of the	ne vehicles listed:		
6. If no			lly within Colorado while working? olorado and list the other states where district employees drive:	Yes	No
7. <i>If ye</i>		ne district transport haz	ardous materials? ansportation of hazardous materials:	Yes	No
8.		ne district haul for othe		Yes	No
ıj ye	s, provide i	ne frequency of trips and the typ	re(s) of items named.		
	If yes,	does the district hold Co	olorado and/or interstate licenses to haul for others?	Yes	No
9.			procedures for: (check all that apply) (Note: We may request to review these ification \(\square\) MVR checks \(\square\) Disciplinary policy	written procedures.)	
10.	Please	provide the following ir	nformation:		
	a.	Average number of m	les driven per trip:		
	b.	Total number of trips	driven per year:		
	c.	Approximate number	of miles driven per year:		
	d.	Average number of en	nployees per vehicle:		



Workers' Compensation Coverage Application Designated Medical Provider Information

District Legal Name:	Date:	
Please complete this form with four (4) provide	e four (4) occupational medical providers who can treat injured employees for ders unless the district is located in a remote area that qualifies for an except before submitting this form. (Please note that the district is not required to pro	tion. The district must confirm the
DESIGNATED MEDIC	CAL PROVIDER DESIGNATED MEDICAL PI	ROVIDER
Provider's Name:	Provider's Name:	
Physician's Name:	Physician's Name:	
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Phone:	Phone:	
DESIGNATED MEDIC	CAL PROVIDER DESIGNATED MEDICAL PI	ROVIDER
Provider's Name:	Provider's Name:	
Physician's Name:	Physician's Name:	
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Phone:	Phone:	

For questions or assistance, please contact us at csdpool@mcgriff.com or 800.318.8870.