

SERFF Tracking Number: LBRM-125378147 State: Arkansas
Filing Company: Bridgefield Casualty Insurance Company State Tracking Number: EFT \$50
Company Tracking Number: 07-WC-AR-0388
TOI: 16.0 Workers Compensation Sub-TOI: 16.0004 Standard WC
Product Name: 07-WC-AR-0388 Policy, PIP, Logo, EPSS
Project Name/Number: 07-WC-AR-0388 Policy, PIP, Logo, EPSS/07-WC-AR-0388

Filing at a Glance

Company: Bridgefield Casualty Insurance Company

Product Name: 07-WC-AR-0388 Policy, PIP, Logo, EPSS SERFF Tr Num: LBRM-125378147 State: Arkansas

TOI: 16.0 Workers Compensation

SERFF Status: Closed

State Tr Num: EFT \$50

Sub-TOI: 16.0004 Standard WC

Co Tr Num: 07-WC-AR-0388

State Status: Fees verified and received

Filing Type: Form

Co Status:

Reviewer(s): Betty Montesi, Carol Stiffler, Brittany Yielding

Authors: Ethel Lee, Liz McCarty

Disposition Date: 12/06/2007

Date Submitted: 12/05/2007

Disposition Status: Approved

Effective Date Requested (New): 03/01/2008

Effective Date (New): 03/01/2008

Effective Date Requested (Renewal): 03/01/2008

Effective Date (Renewal):

State Filing Description:

General Information

Project Name: 07-WC-AR-0388 Policy, PIP, Logo, EPSS

Status of Filing in Domicile: Not Filed

Project Number: 07-WC-AR-0388

Domicile Status Comments: n/a

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 12/06/2007

State Status Changed: 12/06/2007

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

The purpose of this filing is to revise the Workers Compensation and Employers Liability Insurance Policy, the Workers Compensation and Employers Liability Insurance Policy Information Page, and three Premium Summary Statements.

Company and Contact

Filing Contact Information

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Ethel Lee, Regulatory Filing Senior Analyst ethel.lee@summitholdings.com
2310 Commerce Point Drive (800) 282-7648 [Phone]
Lakeland, FL 33801 (863) 667-7232[FAX]

Filing Company Information

Bridgefield Casualty Insurance Company CoCode: 10335 State of Domicile: Florida
2310 Commerce Point Drive Group Code: 111 Company Type: Property &
Lakeland, FL 33801 Group Name: Liberty Mutual Agcy State ID Number:
(800) 282-7648 ext. [Phone] Mkts
FEIN Number: 59-3269531

SERFF Tracking Number: LBRM-125378147 State: Arkansas
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Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: \$50 each filing
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Bridgefield Casualty Insurance Company	\$50.00	12/05/2007	16961781

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Carol Stiffler	12/06/2007	12/06/2007

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Disposition

Disposition Date: 12/06/2007

Effective Date (New): 03/01/2008

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	Cover Letter	Approved	Yes
Supporting Document	Filing Memorandum	Approved	Yes
Form	Workers Compensation and Liability Insurance Company	Approved	Yes
Form	Workers Compensation and Employers Liability Insurance Policy Information Page	Approved	Yes
Form	Estimated Premium Summary Statement, Extension of Information Page WC 99 00 21 A, Item 4	Approved	Yes
Form	Estimated Premium Summary Statement, Extension of Endorsement WC 89 04 15, Item 4	Approved	Yes
Form	Audited Premium Summary Statement, Extension of Endorsement WC 89 04 15, Item 4	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Workers Compensation and Liability Insurance Company	WC 00 00 00 A	DOCU STATE REV 11/07	Policy/Coverage Form Replaced	Replaced Form #:0.00 WC 00 00 00 A, DOCU M-STATE REV 5/06 (06-325) Previous Filing #: 06-WC-AR-0328		BCIC Policy.pdf
Approved	Workers Compensation and Employers Liability Insurance Policy Information Page	WC 99 00 21 A (11/07)	DOCU STATE REV 11/07	Policy/Coverage Form Replaced	Replaced Form #:0.00 WC 00 00 01 A (5/88), BCI/LA351 5/98 (98-270) Previous Filing #: 02-WC-AR-0053		BCIC PIP Page.pdf
Approved	Estimated Premium Summary Statement, Extension of Information Page WC 99 00 21 A, Item 4	WC 99 04 30 A (11/07)	AR	Policy/Coverage Form Replaced	Replaced Form #:0.00 None Previous Filing #: 07-WC-AR-0357		AR EPSS 990021A 11-07 WC990430A .pdf
Approved	Estimated Premium Summary Statement, Extension of Endorsement WC 89 04 15, Item 4	WC 99 04 31 A (11/07)	AR	Endorsement/Amendment/Conditions Replaced	Replaced Form #:0.00 None Previous Filing #: 07-WC-AR-0357		AR EPSS 890415 11-07 WC990431A .pdf
Approved	Audited Premium Summary Statement, Extension of	WC 99 04 32 A (11/07)	AR	Endorsement/Amendment/Conditions Replaced	Replaced Form #:0.00 None Previous Filing #: 07-WC-AR-0357		AR APSS 890415 11-07 WC990432A

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Endorsement WC
89 04 15, Item 4

.pdf

**WORKERS COMPENSATION
AND EMPLOYERS LIABILITY
INSURANCE POLICY**

PLEASE READ THE POLICY CAREFULLY



P.O. Box 988 • Lakeland, FL 33802-0988

**FOR INQUIRIES CALL: SUMMIT CUSTOMER SERVICE
1-800-282-7648 or (863) 665-6060
SUMMIT CLAIMS CENTER**

**To report Notice of Injury, call 1-800-762-7811
For all other claims inquiries, call one of the following:**

- **Florida—1-800-282-7644 or (863) 665-6629**
- **Southeast Region (Georgia, Kentucky, North Carolina, South Carolina and Tennessee)
1-800-863-2181 or (678) 450-5825**
- **Southwest Region (Alabama, Arkansas, Louisiana, and Mississippi)
1-888-468-2539 or (225) 928-0820**

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
QUICK REFERENCE**

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IMPORTANT: This Quick Reference is **not** part of the Workers Compensation and Employers Liability Policy and does **not** provide coverage. Refer to the Workers Compensation and Employers Liability Policy itself for actual contractual provisions.

PLEASE READ THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY CAREFULLY.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows:

GENERAL SECTION

A. The Policy

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. Who Is Insured

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. Workers Compensation Law

Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

D. State

State means any state of the United States of America, and the District of Columbia.

E. Locations

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE: WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers compensation law.

C. We Will Defend

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. Payments You Must Make

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

G. Recovery from Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an

agency authorized by law. Enforcement may be against us or against you and us.

4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
 - a. benefits payable by this insurance; or
 - b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO: EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by ac-

B. We Will Pay

We will pay all sums you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. for which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. for care and loss of services; and
3. for consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee;

provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and

4. because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. Exclusions

This insurance does not cover:

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. bodily injury intentionally caused or aggravated by you;
6. bodily injury occurring outside the United States of

America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;

7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901–950), the Nonappropriated Fund Instrumentalities Act (5 USC Sections 8171–8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331–1356), the Defense Base Act (42 USC Sections 1651–1654), the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 901–942), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51–60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. bodily injury to a master or member of the crew of any vessel;
11. fines or penalties imposed for violation of federal or state law; and
12. damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801–1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages

E. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding, or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

F. Other Insurance

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. Limits of Liability

Our liability to pay for damages is limited. Our limits of liability are shown in Item 3.B. of the Information Page. They apply as explained below.

1. **Bodily Injury by Accident.** The limit shown for “bodily injury by accident—each accident” is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. **Bodily Injury by Disease.** The limit shown for “bodily injury by disease—policy limit” is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for “bodily injury by disease—each employee” is the most we will pay for all damages because of bodily injury by disease to any one employee.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery from Others

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. Actions Against Us

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

PART THREE: OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were listed in Item 3.A. of the Information Page.
3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.
4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the Information

B. Notice

Tell us at once if you begin work in any state listed in Item 3.C. of the Information Page.

PART FOUR: YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.
4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE: PREMIUM

A. Our Manuals

All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

B. Classifications

Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications, rates and premium basis

by endorsement to this policy.

C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. all your officers and employees engaged in work covered by this policy; and
2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

D. Premium Payments

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

E. Final Premium

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

If this policy is canceled, final premium will be determined in the following way unless our manuals provide otherwise:

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.

F. Records

You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. Audit

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX: CONDITIONS

A. Inspection

We have the right, but are not obliged, to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. Long-Term Policy

If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. Transfer of Your Rights and Duties

Your rights or duties under this policy may not be transferred without our written consent.

If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. Cancellation

1. You may cancel this policy. You must mail or deliver

advance written notice to us stating when the cancellation is to take effect.

2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancellation notice.
4. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

E. Sole Representative

The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancellation.

“Executed on behalf of Bridgefield Casualty Insurance Company by its vice president.”



Member of Liberty Mutual Group

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY INFORMATION PAGE

Carrier code _____

Policy number _____

Item 1. Insured

Prior policy number _____

RISK I.D. _____

Name
and
Address

____ Individual ____ Corporation
 ____ Partnership ____ Subchapter "S"
 ____ Other

Other workplaces not shown above:

FEIN _____

Item 2. Policy period

From _____ to _____ 12:01 a.m. standard time at the address of the insured as stated herein.

Item 3. Coverage

- A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here:

- B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are:

Bodily Injury by Accident	\$	each accident
Bodily Injury by Disease	\$	each employee
Bodily Injury by Disease	\$	policy limit

- C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

- D. This policy includes these endorsements and schedules:

Item 4. Premium

The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Classifications	Code No.	Premium Basis: Total Estimated Annual Remuneration	Rate Per \$100 of Remuneration	Estimated Annual Premium

Total Estimated Annual Premium \$ _____

Minimum Premium \$ _____

Expense Constant \$ _____

This policy, including all endorsements issued therewith, is hereby

Countersigned by _____

Date _____

ESTIMATED PREMIUM SUMMARY STATEMENT

CARRIER:

AGENCY:

PHONE NUMBER:

EXTENSION OF INFORMATION PAGE WC 99 00 21 A, ITEM 4

CLIENT:

Account Number:

Policy Period:

Plan:

WORK CODE	CLASSIFICATION	PAYROLL	PRO RATA	RATE	PREMIUM
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Total Manual Premium
 Specific Subrogation Waiver
 Blanket Subrogation Waiver
 Increased Limits Amount
 Balance to IEL Minimum

Drug Free Workplace Credit

Short Rate Amount
 Experience Mod
 Total Modified Premium
 Schedule Rating
 Deduct comp only
 Deduct medical only
 Deduct comp/medical
 Aircraft Seat Surcharge
 Balance to Minimum Premium
 Standard Premium
 Discount
 Expense Constant
 Foreign Terrorism
 Catastrophe Charge
 Policy Grand Total

Minimum Premium:

Date Prepared:

Time Prepared:

WC 99 04 30 A (11/07) AR

ESTIMATED PREMIUM SUMMARY STATEMENT

CARRIER:

AGENCY:

PHONE NUMBER:

EXTENSION OF ENDORSEMENT WC 89 04 15, ITEM 4

CLIENT:

Account Number:

Policy Period:

Plan:

WORK CODE	CLASSIFICATION	PAYROLL	PRO RATA	RATE	PREMIUM
----------------------	-----------------------	----------------	---------------------	-------------	----------------

Total Manual Premium
 Specific Subrogation Waiver
 Blanket Subrogation Waiver
 Increased Limits Amount
 Balance to IEL Minimum

Drug Free Workplace Credit

Short Rate Amount
 Experience Mod
 Total Modified Premium
 Schedule Rating
 Deduct comp only
 Deduct medical only
 Deduct comp/medical
 Aircraft Seat Surcharge
 Balance to Minimum Premium
 Standard Premium
 Discount
 Expense Constant
 Foreign Terrorism
 Catastrophe Charge
 Policy Grand Total

Minimum Premium:

Date Prepared:

Time Prepared:

WC 99 04 31 A (11/07) AR

AUDITED PREMIUM SUMMARY STATEMENT

CARRIER:

AGENCY:

PHONE NUMBER:

EXTENSION OF ENDORSEMENT WC 89 04 15, ITEM 4

CLIENT:

Account Number:

Policy Period:

Plan:

WORK CODE	CLASSIFICATION	PAYROLL	PRO RATA	RATE	PREMIUM
------------------	-----------------------	----------------	-----------------	-------------	----------------

Total Manual Premium
 Specific Subrogation Waiver
 Blanket Subrogation Waiver
 Increased Limits Amount
 Balance to IEL Minimum

Drug Free Workplace Credit

Short Rate Amount
 Experience Mod
 Total Modified Premium
 Schedule Rating
 Deduct comp only
 Deduct medical only
 Deduct comp/medical
 Aircraft Seat Surcharge
 Balance to Minimum Premium
 Standard Premium
 Discount
 Expense Constant
 Foreign Terrorism
 Catastrophe Charge
 Policy Grand Total

Minimum Premium:

Date Prepared:

Time Prepared:

SERFF Tracking Number: *LBRM-125378147* *State:* *Arkansas*
Filing Company: *Bridgefield Casualty Insurance Company* *State Tracking Number:* *EFT \$50*
Company Tracking Number: *07-WC-AR-0388*
TOI: *16.0 Workers Compensation* *Sub-TOI:* *16.0004 Standard WC*
Product Name: *07-WC-AR-0388 Policy, PIP, Logo, EPSS*
Project Name/Number: *07-WC-AR-0388 Policy, PIP, Logo, EPSS/07-WC-AR-0388*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: LBRM-125378147 State: Arkansas
Filing Company: Bridgefield Casualty Insurance Company State Tracking Number: EFT \$50
Company Tracking Number: 07-WC-AR-0388
TOI: 16.0 Workers Compensation Sub-TOI: 16.0004 Standard WC
Product Name: 07-WC-AR-0388 Policy, PIP, Logo, EPSS
Project Name/Number: 07-WC-AR-0388 Policy, PIP, Logo, EPSS/07-WC-AR-0388

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-Property & Casualty **Review Status:** Approved 12/06/2007

Comments:

Attachments:

07-WC-AR-0388 F777 PC TD-1.pdf
07-WC-AR-0388 F778 PC FFS-1.pdf

Satisfied -Name: Cover Letter **Review Status:** Approved 12/06/2007

Comments:

Attachment:

07-WC-AR-0388 ltr.pdf

Satisfied -Name: Filing Memorandum **Review Status:** Approved 12/06/2007

Comments:

Attachment:

Filing Memorandum 07-WC-AR-0388.pdf

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only 	2. Insurance Department Use only a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: <table style="width: 100%; border: none;"> <tr> <td style="width: 70%; border: none;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: h. Subject Codes	New Business		Renewal Business	
New Business					
Renewal Business					

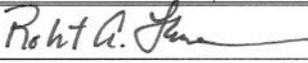
3. Group Name	Group NAIC #
Liberty Mutual Insurance Group	0111

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
Bridgefield Casualty Insurance Company	FL	10335	59-3269531	FL

5. Company Tracking Number	07-WC-AR-0388
-----------------------------------	----------------------

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Mr. Robert A. Laramore Summit Consulting, Inc., MGA	Director of Regulations & Reinsurance	1-800-282-7648	863-667-7218	bob.laramore@ summitholdings.com
	P.O. Box 988 Lakeland, FL 33802-0988				

7. Signature of authorized filer	
8. Please print name of authorized filer	Robert A. Laramore

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	16.0000 Workers Compensation
10. Sub-Type of Insurance (Sub-TOI)	16.0004 Standard WC
11. State Specific Product code(s) (if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	n/a
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: 03/1/2008 Renewal: 03/01/2008
15. Reference Filing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16. Reference Organization (if applicable)	
17. Reference Organization # & Title	
18. Company's Date of Filing	
19. Status of filing in domicile	<input checked="" type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document—

20. This filing transmittal is part of Company Tracking #	07-WC-AR-0388
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21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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See Filing Memorandum

22. Filing Fees (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: EFT
Amount: \$50.00

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #		07-WC-AR-0388		
2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)				
3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement or Withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	Workers Compensation and Employers Liability Insurance Policy	WC 00 00 00 A, DOCU STATE REV 11/07 (07-601)	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	WC 00 00 00 A, DOCU M-STATE REV 5/06 (06-325)	06-WC-AR-0328
02	Workers Compensation and Employers Liability Insurance Policy Information Page	WC 99 00 21 A, (11/07), DOCU STATE 11/07 (07-602)	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	WC 00 00 01 A (5/88), BCI/LA351 5/98 (98-270)	02-WC-AR-0053
03	Estimated Premium Summary Statement, Extension of Information Page WC 99 00 21 A, Item 4	WC 99 04 30 A (11/07) AR	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	None	07-WC-AR-0357
04	Estimated Premium Summary Statement, Extension of Endorsement Wc 89 04 15, Item 4	WC 99 04 31 A (11/07) AR	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	None	07-WC-AR-0357
05	Audited Premium Summary Statement, Extension of Endorsement Wc 89 04 15, Item 4	WC 99 04 32 A (11/07) AR	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	None	07-WC-AR-0357
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		



Rated A (Excellent) by A.M. Best Company

SOUTHWEST REGION

P.O. BOX 80439 ■ BATON ROUGE, LA 70898-0439

(225) 926-3264 ■ 1-800-421-2944

FAX (225) 926-4102

FLORIDA

P.O. BOX 988 ■ LAKELAND, FL 33802-0988

(863) 665-6060 ■ 1-800-282-7648

FAX (863) 666-1958

SOUTHEAST REGION

P.O. BOX 600 ■ GAINESVILLE, GA 30503-0600

(678) 450-5825 ■ 1-800-971-2667

FAX (770) 531-1349

December 5, 2007

Ms. Julie Benafield Bowman, Insurance Commissioner
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: Bridgefield Casualty Insurance Company
Workers Compensation Insurance
Revised Filing of Workers Compensation Policy and Forms
NAIC Number 10335
BCIC Filing Number 07-WC-AR-0388

Dear Ms. Bowman:

Bridgefield Casualty Insurance Company is licensed to write workers compensation insurance in the state of Arkansas. At this time we are submitting for your review and approval revised Workers Compensation and Employers Liability Insurance Policy, Workers Compensation and Employers Liability Insurance Policy Information Page, and three Premium Summary Statements. An effective date of March 1, 2008 is requested.

Included in this filing are:

1. Cover Letter
2. Filing Memorandum
3. Property & Casualty Transmittal Document (PC TD-1)
4. Form Filing Schedule (PC-FFS-1)
5. Workers Compensation and Employers Liability Insurance Policy, WC 00 00 00 A, DOCU STATE REV 11/07 (07-601)
6. Workers Compensation and Employers Liability Insurance Policy Information Page, WC 99 00 21 A (11/07), DOCU STATE REV 11/07 (07-602)
7. Estimated Premium Summary Statement, Extension of Information Page WC 99 00 21 A, Item 4, WC 99 04 30 A (11/07) AR
8. Estimated Premium Summary Statement, Extension of Endorsement WC 89 04 15, Item 4, WC 99 04 31 A (11/07) AR
9. Audited Premium Summary Statement, Extension of Endorsement WC 89 04 15, Item 4, WC 99 04 32 A (11/07) AR

Ms. Julie Benafield Bowman, Insurance Commissioner
Arkansas Department of Insurance
BCIC Filing Number: 07-WC-AR-0388
Page 2
December 5, 2007

Please send all questions and correspondence to: Bridgefield Casualty Insurance Company
ATTN: Robert Laramore
P.O. Box 988
Lakeland, FL 33802-0988

Email: bob.laramore@summitholdings.com
Phone 1-800-282-7648, ext. 3652

To the best of my knowledge, this filing is in compliance with the statutes, rules regulations of the State of Arkansas.

Sincerely,



Robert A. Laramore
Director of Regulation & Reinsurance
Summit Consulting, Inc.,
Managing General Agent

RAL/lm

Enclosures

Filing Memorandum
Bridgefield Casualty Insurance Company
07-WC-AR-0388

Purpose

The purpose of this filing is to revise the Workers Compensation and Employers Liability Insurance Policy, the Workers Compensation and Employers Liability Insurance Policy Information Page, and three Premium Summary Statements.

Proposal

1. Workers Compensation and Employers Liability Insurance Policy, WC 00 00 00 A, DOCU M-STATE REV 5/06 (06-325)
 - a. Change the logo and add “Member of Liberty Mutual Group” on cover page.
 - b. Delete the typed name and signature of Ricky T. Hodges from page 8.
 - c. Change the edition to: DOCU STATE REV 11/07 (07-601).

2. Workers Compensation and Employers Liability Policy Information Page, WC 00 00 01 A (5/88), BCI/LA351 5/98 (98-270)
 - a. Change the logo and add “Member of Liberty Mutual Group”.
 - b. Change the number to: WC 99 00 21 A (11/07), DOCU STATE REV 11/07 (07-602).

3. Estimated Premium Summary Statement, Extension of Information Page WC 99 00 21 A, Item 4
 - a. Move “Estimated Premium Summary Statement” to the top of the page.
 - b. Remove “Page”.
 - c. Change “Extension of Information Page WC 00 00 01 A” to “Extension of Information Page WC 99 00 21 A, Item 4”.
 - d. Change “Client Number” to “Account Number”.
 - e. Move “Plan” to left margin.
 - f. Add number and edition “WC 99 04 30 A (11/07) AR” to bottom left-hand side of form.

4. Estimated Premium Summary Statement, Extension of Endorsement WC 89 04 15, Item 4
 - a. Move “Estimated Premium Summary Statement” to the top of the page.
 - b. Remove “Page”.
 - c. Change “Extension of Endorsement WC 89 04 15” to “Extension of Information Page WC 89 04 15, Item 4”.
 - d. Change “Client Number” to “Account Number”.
 - e. Move “Plan” to left margin.
 - f. Add number and edition “WC 99 04 31 A (11/07) AR” to bottom left-hand side of form.

5. Audited Premium Summary Statement, Extension of Endorsement WC 89 04 15,
Item 4

- a. Move “Audited Premium Summary Statement” to the top of the page.
- b. Remove “Page”.
- c. Change “Extension of Endorsement WC 89 04 15” to “Extension of Endorsement WC 89 04 15, Item 4”.
- d. Change “Client Number” to “Account Number”.
- e. Move “Plan” to left margin.
- f. Add number and edition “WC 99 04 32 A (11/07) AR” to bottom left-hand side of form.

Impact

This filing will not affect current premium levels.

Proposed Effective Date

Bridgefield Casualty Insurance Company requests an effective date of March 1, 2008