

SERFF Tracking Number: EMCC-125796303 State: Arkansas
First Filing Company: EMC Property & Casualty Company, ... State Tracking Number: EFT \$50
Company Tracking Number: AR-WC-2008-05
TOI: 16.0 Workers Compensation Sub-TOI: 16.0004 Standard WC
Product Name: Form Filing
Project Name/Number: /

Filing at a Glance

Companies: EMC Property & Casualty Company, EMCASCO Insurance Company, Employers Mutual Casualty Company, Union Insurance Company of Providence

Product Name: Form Filing SERFF Tr Num: EMCC-125796303 State: Arkansas
TOI: 16.0 Workers Compensation SERFF Status: Closed State Tr Num: EFT \$50
Sub-TOI: 16.0004 Standard WC Co Tr Num: AR-WC-2008-05 State Status: Fees verified and received
Filing Type: Form Co Status: Reviewer(s): Betty Montesi, Carol Stiffler, Brittany Yielding
Author: Stephanie McBride Disposition Date: 08/29/2008
Date Submitted: 08/28/2008 Disposition Status: Approved
Effective Date Requested (New): 11/01/2008 Effective Date (New): 11/01/2008
Effective Date Requested (Renewal): 11/01/2008 Effective Date (Renewal):
State Filing Description:

General Information

Project Name: Status of Filing in Domicile:
Project Number: Domicile Status Comments:
Reference Organization: Reference Number:
Reference Title: Advisory Org. Circular:
Filing Status Changed: 08/29/2008
State Status Changed: 08/29/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:
August 28, 2008

EMPLOYERS MUTUAL CASUALTY COMPANY – 062-21415
EMCASCO INSURANCE COMPANY – 062-21407
UNION INSURANCE COMPANY OF PROVIDENCE – 062-21423
EMC PROPERTY & CASUALTY COMPANY – 062-25186

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Workers Compensation

Form Filing

Introducing Union Insurance Company of Providence and EMC Property & Casualty Company

Filing Retention Dividend Plan

Company File #: AR-WC-2008-05

Effective: November 1, 2008

The captioned companies are members of the National Council on Compensation Insurance and NCCI files the workers compensation program on our behalf. With this filing, we are submitting for your review and approval forms that will be applicable to our newly introduced companies of Union Insurance Company of Providence and EMC Property & Casualty Company. Please refer to the attached forms list. These forms have been filed and approved for both Employers Mutual Casualty Company and EMCASCO Insurance Company. These forms will be applicable to policies effective on or after November 1, 2008. The corresponding rate/rule filing will be sent under separate cover.

We are also submitting a revised Benefits Deductible Endorsement for all companies. Form WC8061 (2-07) will replace WC8061 (Ed. 9-99) that was previously filed and approved for Employers Mutual and EMCASCO.

Lastly, we are filing a Retention Dividend Plan for all companies. Please see the attached explanatory memorandum for an explanation of this plan.

Please find attached the Transmittal Document, forms list, explanatory memorandum, Retention Dividend Plan endorsement, and copies of all the endorsements to apply to our new companies. A filing fee in the amount of \$50 is available via EFT.

We respectfully request your approval of this filing to be applicable to policies effective on or after November 1, 2008.

Stephanie McBride

Filings Analyst

Rates and Filings Dept.

800-247-2128 Ext. 2684

Stephanie.M.McBride@EMCIns.com

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Company and Contact

Filing Contact Information

Stephanie McBride, Filings Analyst
 PO Box 712
 Des Moines, IA 50306-0712
 Stephanie.M.McBride@EMCIns.com
 (515) 345-2684 [Phone]
 (515) 345-2223[FAX]

Filing Company Information

EMC Property & Casualty Company	CoCode: 25186	State of Domicile: Iowa
717 Mulberry Street	Group Code: 62	Company Type: P & C
Des Moines, IA 50309	Group Name:	State ID Number:
(800) 247-2128 ext. [Phone]	FEIN Number: 63-0329091	

EMCASCO Insurance Company	CoCode: 21407	State of Domicile: Iowa
717 Mulberry Street	Group Code: 62	Company Type: P & C
Des Moines, IA 50309	Group Name:	State ID Number:
(800) 247-2128 ext. [Phone]	FEIN Number: 42-6070764	

Employers Mutual Casualty Company	CoCode: 21415	State of Domicile: Iowa
717 Mulberry Street	Group Code: 62	Company Type: P & C
Des Moines, IA 50309	Group Name:	State ID Number:
(800) 247-2128 ext. [Phone]	FEIN Number: 42-0234980	

Union Insurance Company of Providence	CoCode: 21423	State of Domicile: Iowa
717 Mulberry Street	Group Code: 62	Company Type: P & C
Des Moines, IA 50309	Group Name:	State ID Number:
(800) 247-2128 ext. [Phone]	FEIN Number: 05-0230479	

Filing Fees

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

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
EMC Property & Casualty Company	\$50.00	08/28/2008	22186545
EMCASCO Insurance Company	\$0.00	08/28/2008	
Employers Mutual Casualty Company	\$0.00	08/28/2008	
Union Insurance Company of Providence	\$0.00	08/28/2008	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Carol Stiffler	08/29/2008	08/29/2008

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Disposition

Disposition Date: 08/29/2008

Effective Date (New): 11/01/2008

Effective Date (Renewal):

Status: Approved

Comment: This was accidentally closed as informational only which was incorrect. It is approved.

Rate data does NOT apply to filing.

Overall Rate Information for Multiple Company Filings

Overall Percentage Rate Indicated For This Filing	0.000%
Overall Percentage Rate Impact For This Filing	0.000%
Effect of Rate Filing-Written Premium Change For This Program	\$0
Effect of Rate Filing - Number of Policyholders Affected	0

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	Forms List	Approved	Yes
Supporting Document	Explanatory Memo	Approved	Yes
Form	Waiver of Our Right to Recover From Others Endorsement	Approved	Yes
Form	Workers Compensation and Employers Liability Insurance Policy	Approved	Yes
Form	Workers Compensation and Employers Liability Insurance Policy	Approved	Yes
Form	Workers Compensation Classification of Operations Schedule	Approved	Yes
Form	Quick Reference	Approved	Yes
Form	Arkansas Benefits Deductible Endorsement	Approved	Yes
Form	Retention Dividend Plan	Approved	Yes

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Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Waiver of Our Right to Recover From Others Endorsement	WC 00 03 13	4-84	Endorsement/Amendment/Conditions			WC000313.pdf
Approved	Workers Compensation and Employers Liability Insurance Policy	WC7000	1-99	Policy/Coverage Form			WC7000.pdf
Approved	Workers Compensation and Employers Liability Insurance Policy	WC7002	9-86	Declaration News/Schedule			WC7002 ED. 09-86.pdf
Approved	Workers Compensation Classification of Operations Schedule	WC7003	9-86	Declaration News/Schedule			WC7003 ED. 09-86.pdf
Approved	Quick Reference	WC7005	4-92	Endorsement/Amendment/Conditions			WC7005_19 9204.pdf
Approved	Arkansas Benefits Deductible Endorsement	WC8061	2-07	Endorsement/Amendment/Conditions			WC8061_20 0702.pdf
Approved	Retention Dividend Plan	WC8063.25-08		Endorsement/Amendment/Conditions			WC8063.2_2 00805.pdf

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. (This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us.)

This agreement shall not operate directly or indirectly to benefit anyone not named in the Schedule.

Schedule

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement
Insured

Effective Policy No.

Endorsement No.
Premium

Insurance Company

Countersigned by _____

WC 00 03 13
(Ed. 4-84)

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

PRIOR
POL. NO.

POLICY
NUMBER

Policy Period From: _____ To: _____
(12:01 AM Standard Time at Your Mailing Address Shown Below)

Named Insured _____

Mailing Address _____

Other work places not shown above** _____

The Named Insured is Individual Corporation Partnership Joint Venture Other _____

Producer _____

SIC Code _____ Fed. I.D. No. _____ Bureau I.D. No. _____ Business Description _____

EMC Insurance Companies

- | | |
|--|---|
| <input type="checkbox"/> Employers Mutual Casualty Company | <input type="checkbox"/> Dakota Fire Insurance Company |
| <input type="checkbox"/> EMCASCO Insurance Company | <input type="checkbox"/> Illinois EMCASCO Insurance Company |
| <input type="checkbox"/> Union Insurance Company of Providence | <input type="checkbox"/> EMC Property & Casualty Company |
| <input type="checkbox"/> Hamilton Mutual Insurance Company | |

(Coverage Provided by the Company Designated Above)

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 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: All states except Maine, North Dakota, Ohio, Washington, West Virginia, Wyoming, States designated in Item A. and

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
<div style="text-align: right; margin-right: 50px;"> Premium for increased limits Part Two, if applicable Total Premium Subject to the Experience Modification Premium modified to reflect Experience Modification of Loss Constant Premium Discount Expense Constant </div>				
			TOTAL ESTIMATED ANNUAL PREMIUM	\$

**ABSENCE OF AN ENTRY MEANS "NO EXCEPTION."
MINIMUM PREMIUM \$

If indicated, interim adjustments of premium shall be made:
 Semi-Annually Quarterly Monthly Deposit Premium \$
 ENDORSEMENTS:

Date of Issue _____ Issued from _____ Countersigned by _____
Authorized Representative

XXXXXXXXXXXXXXXXXXXXXXXXX COMPANY: AMEXXXXXXXXXXXXXXXXXX POLICY NUMBER: XXX-XX-XX---XX
NAMED INSUREDXXXXXXXXXXXXXXXXX^XXXXX EFF DATE: MM/DD/YY: EXP DATE: MM/DD/YY
WC000001A

(AR & OK) SMALL DEDUCTIBLE CREDIT	.\$-X,XXX,XXX.XX
CONNECTICUT SECOND INJURY FUND SURCHARGE	.\$ X,XXX,XXX.XX
DEDUCTIBLE CREDIT 0.100 (9999)	.\$-X,XXX,XXX.XX
\$999,999 EACH OCCURRENCE	.
\$999,999 PER EMPLOYEE	.
(OR) \$999,999 AGGREGATE	.
XX% OF XXXXXXXXXXXXXXXXXXXXXXXX, AGGREGATE	
\$X, NA XXX MINIMUM AGGREGATE	
ASSIGNED RISK ADJUSTMENT PROGRAM (X.XXX)	.\$ X,XXX,XXX.XX
ASSIGNED RISK RATING PROGRAM SURCHARGE (X.XXX)	.\$ X,XXX,XXX.XX
CONSTRUCTION /CONTRACTING ADJUSTMENT - CODE 9046 (.XX)	.\$-X,XXX,XXX.XX
STATE DEVIATION ADJUSTMENT (.XX)	.\$ X,XXX,XXX.XX
AIRCRAFT SEAT SURCHARGE - CODE 9108	.\$ X,XXX,XXX.XX
WISCONSIN WAIVER OF SUBROGATION - CODE 9115	.\$ X,XXX,XXX.XX
LOSS CONSTANT	.\$ X,XXX,XXX.XX
WORKPLACE SAFETY PROGRAM CREDIT - CODE 9880	.\$-X,XXX,XXX.XX
SAFETY AND HEALTH ACHIEVEMENT RECOG. PROG. - CODE XXXX	.\$ X,XXX,XXX.XX
DRUG-FREE WORKPLACE PREMIUM CREDIT	.\$-X,XXX,XXX.XX
MANAGED CARE PROGRAM - CODE 9874	.\$ X,XXX,XXX.XX
WORKPLACE SAFETY PREMIUM DEBIT	.\$ X,XXX,XXX.XX
MISSOURI SAFETY CERTIFICATION PREMIUM ADJUSTMENT	.\$ X,XXX,XXX.XX
CERTIFIED RISK MANAGEMENT CREDIT	.\$ X,XXX,XXX.XX
DESIGNATED MEDICAL PROVIDER CREDIT	.\$ X,XXX,XXX.XX

STATE TOTAL ESTIMATED STANDARD PREMIUM	.\$ X,XXX,XXX.XX
PA CERTIFIED SAFETY COMMITTEE CREDIT PROGRAM	.\$-X,XXX,XXX.XX
CLASS CODE 0063/0064 ESTIMATED PREMIUM DISCOUNT	.\$ X,XXX,XXX.XX
ALL RISK ADJUSTMENT PROGRAM (X.XXX)	.\$-X,XXX,XXX.XX
TERRORISM RISK INSURANCE ACT - CODE 9740 (RATE .XX)	.\$ X,XXX,XXX.XX
DOM TERRORISM/E-QUAKE/CAT INDUST ACC - CODE 9741 (RATE .XX)	.\$ X,XXX,XXX.XX

STATE SUBTOTAL	.\$ X,XXX,XXX.XX
DC WORKERS COMPENSATION POLICYHOLDER SURCHARGE	.\$ X,XXX,XXX.XX
MASSACHUSETTS ASSESSMENT	.\$ X,XXX,XXX.XX
MISSOURI SECOND INJURY SURCHARGE	.\$ X,XXX,XXX.XX
SECOND INJURY FUND SURCHARGE - NJ - CODE 0935	.\$ X,XXX,XXX.XX
UNINSURED EMPLOYERS FUND SURCHARGE - NJ - CODE 0936	.\$ X,XXX,XXX.XX
CA GUAR. ASSOC. RECOUP.	.\$ X,XXX,XXX.XX
CA WC ASSESSMENT	.\$ X,XXX,XXX.XX
OREGON ASSESSMENT	.\$ X,XXX,XXX.XX
KENTUCKY SPECIAL FUND ASSESSMENT	.\$ X,XXX,XXX.XX
MIGA SURCHARGE	.\$ X,XXX,XXX.XX
9877 - PREMIUM SURCHARGE UNDER FRESH START PROGRAM	.\$ X,XXX,XXX.XX
CONNECTICUT ASSESSMENT FUND	.\$ X,XXX,XXX.XX
INDIANA PROOF OF COVERAGE FILING FEE	.\$ X,XXX,XXX.XX

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

(Ed. 4-92)

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 and 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 accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

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 payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

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.

(Ed. 4-92)

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 Page, coverage will not be afforded for that state unless we are notified within thirty days.

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.
2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short-rate cancellation table and procedure. Final premium will not be less than 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.

(Ed. 4-92)

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.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The Information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective	Policy No.	Endorsement No.
Insured		Premium \$
Insurance Company	Countersigned by _____	

WORKERS COMPENSATION DEDUCTIBLE (ARKANSAS)

Date

Producer		Insured Name and Mailing Address:		
Code	Subcode	Website Address		
		Effective Date	Expiration Date	Policy/Account Number

Arkansas Workers Compensation Law requires us to offer optional deductibles to you for either Indemnity and Medical, Medical, or Indemnity benefits, payable under your Workers Compensation Policy. A sample endorsement is printed on the reverse side of this notice, explaining how the deductible will be applied and your obligations should you elect it. **If you are interested in a deductible, please select ONLY ONE (1) of the options shown below, sign, and return this notice to your agent.**

INDEMNITY AND MEDICAL

Deductible Amount	Premium Credit: Based on Hazard Group			
	I	II	III	IV
<input type="checkbox"/> \$1,000	5.5%	5.3%	3.1%	2.2%
<input type="checkbox"/> \$1,500	6.7%	6.5%	3.8%	2.8%
<input type="checkbox"/> \$2,000	7.8%	7.5%	4.5%	3.3%
<input type="checkbox"/> \$2,500	8.7%	8.3%	5.1%	3.7%
<input type="checkbox"/> \$3,000	9.6%	9.1%	5.7%	4.1%
<input type="checkbox"/> \$3,500	10.4%	9.9%	6.2%	4.5%
<input type="checkbox"/> \$4,000	11.1%	10.5%	6.6%	4.8%
<input type="checkbox"/> \$4,500	11.8%	11.1%	7.1%	5.2%
<input type="checkbox"/> \$5,000	12.4%	11.7%	7.5%	5.5%

MEDICAL

Deductible Amount	Premium Credit: Based on Hazard Group			
	I	II	III	IV
<input type="checkbox"/> \$1,000	5.3%	5.1%	3.0%	2.2%
<input type="checkbox"/> \$1,500	6.4%	6.2%	4.2%	3.1%
<input type="checkbox"/> \$2,000	7.3%	7.0%	4.2%	3.1%
<input type="checkbox"/> \$2,500	8.1%	7.7%	4.7%	3.4%
<input type="checkbox"/> \$3,000	8.7%	8.3%	5.1%	3.7%
<input type="checkbox"/> \$3,500	9.3%	8.9%	5.5%	4.0%
<input type="checkbox"/> \$4,000	9.9%	9.4%	5.8%	4.3%
<input type="checkbox"/> \$4,500	10.4%	9.9%	6.2%	4.5%
<input type="checkbox"/> \$5,000	10.9%	10.3%	6.5%	4.7%

INDEMNITY

Deductible Amount	Premium Credit: Based on Hazard Group			
	I	II	III	IV
<input type="checkbox"/> \$1,000	1.4%	1.2%	0.9%	0.6%
<input type="checkbox"/> \$1,500	1.9%	1.7%	1.3%	0.8%
<input type="checkbox"/> \$2,000	2.4%	2.2%	1.6%	1.1%
<input type="checkbox"/> \$2,500	2.8%	2.5%	1.8%	1.3%
<input type="checkbox"/> \$3,000	3.2%	2.9%	2.1%	1.5%
<input type="checkbox"/> \$3,500	3.6%	3.2%	2.4%	1.6%
<input type="checkbox"/> \$4,000	4.0%	3.5%	2.6%	1.8%
<input type="checkbox"/> \$4,500	4.3%	3.8%	2.8%	1.9%
<input type="checkbox"/> \$5,000	4.6%	4.1%	3.1%	2.1%

I Understand that the company will pay the deductible amount and shall be fully reimbursed by the named insured shown below within 30 days of billing.

Insured Signature

Date



ARKANSAS BENEFITS DEDUCTIBLE ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Arkansas is shown in Item 3.A. of the Information Page.

1. Part One (Workers Compensation Insurance) applies only to benefits in excess of the deductible amount shown in the Schedule.
2. This deductible applies separately to each claim for bodily injury by accident or disease.
3. We will pay the deductible amount for you, but you must reimburse us within 30 days after we send you notice that payment is due. If you fail to fully reimburse us, we may cancel the policy as provided in Part Six (Conditions), Section D. Cancellation, of the policy. We may keep the amount of unearned premium that will reimburse us for the payments we made. These rights are in addition to other rights we have to be reimbursed.

Schedule

**Indemnity and Medical
Deductible Amount**

**Medical Deductible
Amount**

**Indemnity Deductible
Amount**

RETENTION DIVIDEND PLAN

This endorsement adds a Retention Dividend Plan to the Policy.

A. Plan Eligibility:

The Retention Plan applies only to risks earning an annual standard premium of \$50,000 or more. Eligibility for a dividend is determined in accordance with the retention formula stated below.

B. Dividend Eligibility:

1. Retention Formula:

$$\begin{array}{r}
 \text{Standard Premium} \\
 - \text{Premium Discount} \\
 \text{Guaranteed Cost Premium} \\
 \times \text{Retention Factor} \\
 \text{Retained Premium} \\
 + \text{Losses Incurred} \times \text{Loss Conversion Factor} \\
 + \text{Paid Allocated Loss Adjustment Expense} \\
 \text{Net Cost to the Insured} \\
 \\
 \text{Guaranteed Cost Premium} \\
 - \text{Net Cost to the Insured} \\
 \text{Indicated Dividend}
 \end{array}$$

NOTE: Workers' Compensation dividends are fixed, paid from surplus and determined by the Board of Directors in accordance with the law and cannot be legally guaranteed. However, the company has paid dividends under this or comparable plans continuously since 1944.

2. Estimated Retention Factor:

The retained premium as calculated subject to the retention plan is a percentage of the guaranteed cost premium for this insurance. Such percentages are computed initially upon an estimate of the standard premium and finally upon the earned standard premium for this insurance. If the final standard premium is not as estimated, the retention factor may be recalculated.

3. Loss Conversion Factor:

Provisions for Unallocated Loss Adjustment Expense are determined by multiplying incurred losses by the loss conversion factor. This factor may also reflect loss-based assessments if applicable in the states included in this plan.

4. The premium, losses and claim expense for the following states are to be combined and computed in accordance with the provisions of the retention plan.

C. Valuation for Dividend Return:

The first valuation date is 18 months after inception of the policy - 50% of the indicated dividend will be returned. Any dollar amount returned will be guaranteed in that we will not ask for any of this money back if further losses develop or reserves go up during our valuation process.

The second valuation date is 30 months after inception of the policy - indicated dividend at the 30 month valuation minus indicated dividend at the 18 month valuation will be returned, assuming the difference is positive. Once this second valuation is made, the plan is closed out, and further valuations will not be considered.

D. Cancellations:

Policies cancelled by the insured will terminate plan. No dividend of any type will be applicable.

Policies cancelled by the insurer:

1. For nonpayment of premium will automatically terminate the retention plan, and no dividend of any type will be applicable.
2. For any other reason, will be valued as of the cancellation date for eligibility, and if the policy qualifies, the retention plan valuation will be done six months after the cancellation date.

This endorsement changes the policy to which it is attached and is effective on the inception date unless otherwise stated.

SERFF Tracking Number: *EMCC-125796303* *State:* *Arkansas*
First Filing Company: *EMC Property & Casualty Company, ...* *State Tracking Number:* *EFT \$50*
Company Tracking Number: *AR-WC-2008-05*
TOI: *16.0 Workers Compensation* *Sub-TOI:* *16.0004 Standard WC*
Product Name: *Form Filing*
Project Name/Number: */*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: EMCC-125796303 State: Arkansas
First Filing Company: EMC Property & Casualty Company, ... State Tracking Number: EFT \$50
Company Tracking Number: AR-WC-2008-05
TOI: 16.0 Workers Compensation Sub-TOI: 16.0004 Standard WC
Product Name: Form Filing
Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Uniform Transmittal Document-Property & Casualty
Review Status: Approved 08/29/2008

Comments:

Attachment:

P&C Transmittal- 11-08 Form Rev.pdf

Satisfied -Name: Forms List
Review Status: Approved 08/29/2008

Comments:

Attachment:

Forms List.pdf

Satisfied -Name: Explanatory Memo
Review Status: Approved 08/29/2008

Comments:

Attachment:

Div. Plan Memorandum.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 border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">New Business</td> <td></td> </tr> <tr> <td>Renewal Business</td> <td></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 #
EMC Insurance Companies	062

4. Company Name(s)	Domicile	NAIC #	FEIN #
Employers Mutual Casualty Company	IA	21415	42-0234980
EMCASC0 Insurance Company	IA	21407	42-6070764
Union Insurance Company of Providence	IA	21423	05-0230479
EMC Property & Casualty Company	IA	25186	63-0329091

5. Company Tracking Number	AR-WC-2008-05
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Stephanie McBride P. O. Box 712 Des Moines IA 50306	Filings Analyst	800-247-2128 Ext. 2684	515-345-2223	Stephanie.M.McBride @EMCIns.com
7.	Signature of authorized filer				
8.	Please print name of authorized filer		Stephanie McBride		

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

9.	Type of Insurance (TOI)	16.0000
10.	Sub-Type of Insurance (Sub-TOI)	16.0004
11.	State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12.	Company Program Title (Marketing title)	Workers Compensation
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: 11/1/08 Renewal: 11/1/08

ARKANSAS
WORKERS COMPENSATION
FORMS LIST

WC 00 03 13 (Ed. 4-84) Waiver of Our Right to Recover From Others Endorsement

WC7000 (Ed. 1-99) Workers Compensation and Employers Liability Insurance Policy

WC7002 (ED. 09-86) Workers Compensation and Employers Liability Insurance Policy

WC7003 (ED. 09-86) Workers Compensation Classification of Operations Schedule

WC7005 (Ed. 4-92) Quick Reference

WC8061 (02-07) Arkansas Benefits Deductible Endorsement

EXPLANATORY MEMORANDUM
WORKERS COMPENSATION RETENTION DIVIDEND PLAN

This program rewards eligible insureds for favorable Workers Compensation loss experience. It is a plan where a remaining dividend is payable after deduction of expenses and covered losses from a discounted premium. The plan encourages accident prevention measures and safety/loss control improvement.

The Retention Dividend Plan offers increased flexibility within a competitive marketplace and is essentially an alternative dividend payout plan approach, available for use with larger sized entities. The plan applies only to Workers Compensation with annual minimum standard premium of \$50,000 or more. The insured would qualify by meeting the majority of the following requirements:

- A loss ratio less than or equal to 45% (undeviated standard premium).
- Supporting lines of coverage with Workers Compensation representing less than or equal to 50% of account premium.
- Safety/loss control/inspection implementation.
- Hazard Group 3 or below.
- No aviation, longshoremen exposures, or exposures excluded from treaty.
- Experience mod less than or equal to 1.00.
- Agent's commission less than or equal to 5%.

Coverage under this program will be affected by attaching Endorsement WC8063.2 (Ed.5-08) to the standard Workers Compensation and Employers Liability Policy.

The indicated dividend amount to be paid is calculated by determining the guaranteed cost premium for the policy year (guaranteed cost premium = standard premium minus premium discount) and subcontracting the retention provision (retention factor x guaranteed cost premium), converted losses, and paid allocated loss adjustment expenses. Guaranteed cost premium shall not include expense constants, loss constants, nor any special state assessments, surcharges, recoupments or filing fees.

For each policy year, the indicated dividend will be calculated at 18 months and at 30 months after inception. The first dividend payment will equal 50% of the indicated dividend at the 18 month evaluation. The second dividend payment will equal the indicated dividend at the 30 month evaluation minus the first dividend payment, assuming the difference is positive. If negative, no additional dividend is payable. No further dividend evaluations will be calculated after the 30 month evaluation.

NOTE: Workers Compensation dividends are fixed, paid from surplus and determined by the Board of Directors in accordance with the law and cannot be legally guaranteed. However, the company has paid dividends under this or comparable plans continuously since 1944.

WORKERS' COMPENSATION RETENTION PLAN

DIVIDEND PLAN FACTORS

<u>Policy Year Standard Premium</u>	<u>Retention Factor</u>
\$50,000 - 64,999	.35
65,000 - 79,999	.325
80,000 - 99,999	.30
100,000 and over	Refer to Company

NOTES

- 1) If the policy is subject to agent's profit share, the retention factors are to be increased by 0.030.
- 2) The retention factors contemplate 5% commission. If the commission rate is not 5%, the retention factors may be adjusted.
- 3) The retention factors may be increased to include projected residual market burdens.

LOSS CONVERSION FACTOR

<u>Standard Premium</u>	<u>Loss Conversion Factor</u>
\$0 - 99,999	1.11
100,000 and over	Refer to Company

This factor will be adjusted as needed to include loss-based assessments for which there is not adequate provision in the retention factor.

NOTES

- 1) Retention factors do not include provisions for unallocated loss adjustment expenses. Provision for ULAE is determined by multiplying incurred losses by the loss conversion factor.
- 2) The retention and loss conversion factors will be reviewed annually and are subject to adjustment.