NOTICE TO EMPLOYEES

WORKERS' COMPENSATION

Employer Name: EASTERN KENTUCKY UNIVERSITY

The above named employer, an employer within the meaning of the Workers' Compensation Law of the State of Nebraska, hereby gives notice to employees that the employer has secured the payment of Compensation to its employees and their dependents in accordance with the provision of said law, by insuring with:

Insurance Company: ZURICH AMERICAN INSURANCE COMPANY
1299 ZURICH WAY
SCHAUMBURG, IL 60196-5870
800-987-3373

Policy Effective Dates: 7/1/2017 to 7/1/2018

Policy Number: WC 009015351-03

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Claims Administered By: ZURICH CLAIMS SERVICES
PO BOX 49547
COLORADO SPRINGS, CO 80949-9537
Telephone 800-987-3373

Collecting Workers' Compensation benefits by intentionally misrepresenting, misstating, or failing to disclose any material fact is **fraud**. Fraudulent claims are subject to prosecution. All suspected violations will be investigated. Anyone may report a potentially fraudulent claim by contacting the Workers' Compensation Division or Attorney General's office.

POSTING LOCATION: [EASTERN KENTUCK] 3109 LONE TREE, BELLEVUE, NE 68123

Date Posted: 7/7/2017

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with the

ZURICH AMERICAN INSURANCE COMPANY
(Insurance Company Name)

for the period

Beginning 7/1/2017 **Ending** 7/1/2018

Employer EASTERN KENTUCKY UNIVERSITY

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT
NOTIFICACION DE ACCIDENTE O ENFERMEDAD DE OFICIO

In accordance with New Mexico law, Section 52-1-29, Section 52-3-19 and Section 52-1-49, NMSA 1978; NMAC 11.4.4.11
Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29 ,Sección 52-3-19 y Sección 52-1-49, NMSA 1978; NMAC 11.4.4.11

I, _____, was involved in an on-the-job accident or was disabled
Yo, (name of employee/*nombre del empleado*) *me lastimé en un accidente en el trabajo o fui incapacitado*

by an occupational disease at approximately _____, on _____, 20_____.
por enfermedad de oficio aproximadamente (time/*a la(s) hora(s)*) *el* (date/*fecha*) *del 20*_____.

Employee's social security number: _____ Where did the accident occur? _____
Número de suguro social del empleado: *¿Dónde ocurrió el accidente?*

What happened? _____
¿Qué ocurrió?

_____

_____

To be completed by Employer:
Completado por el empleador:
If Yes, Employer has right to change health care provider after 60 days.
En caso afirmativo, el empleador tiene derecho a cambier de proveedor de atención médica después de 60 dias.

Worker will choose health care provider. Yes___ No___
Trabajador elegir proveedor de atención médica.
If No, Worker has the right to change health care provider after 60 days.
En caso que no elige, el trabajor tiene derecho a cambiar de proveedor de atención médica después de 60 dias.

WORKER MUST INITIAL ____ ***INICIALES DEL TRABAJADOR***

Signed: _____ Signed/Notice Received: _____
Firma: (employee/*empleado*) *Firma/Notificación recibida:* (employer or representative/*empleador o representante*)
Date/Fecha: _____ Date/*Fecha*: _____

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

PREVIOUS NOA FORMS ARE STILL VALID FOR USE

Worker --
For emergency medical care, go to any emergency medical facility.

Workers and Employers with questions about workers' compensation may contact an Ombudsman at any New Mexico Workers' Compensation Administration office for information and assistance. The offices are open Monday through Friday, 8 a.m. to 5 p.m., except holidays.

Trabajador
Para emergencias médicas vaya a cualquier clinica / hospital.

Trabajadores y empleadores con preguntas acerca de la compensación de los trabajadores pueden comunicarse con un asesor ("ombudsman") a cualquier oficina de la Administración de la Compensación de los Trabajadores para información y asistencia. Las oficinas están abiertas desde las ocho de la mañana hasta las cinco de la tarde de lunes a viernes, con la excepción de dias festivos.

Statewide Helpline -- *Linea de Asistencia*

1-866-WORKOMP / 1-866-967-5667

toll free -- *llamada sin costo de larga distancia*

New Mexico Workers' Compensation Administration
PO Box 27198, Albuquerque, NM 87125

Albuquerque: (505) 841-6000 - 1 (800) 255-7965
Farmington: (505) 599-9746 - 1 (800) 568-7310
Las Cruces: (575) 524-6246 - 1 (800) 870-6826
Las Vegas: (505) 454-9251 - 1 (800) 281-7889
Lovington: (575) 396-3437 - 1 (800) 934-2450
Roswell: (575) 623-3997 - 1(866) 311-8587
Santa Fe: (505) 476-7381
TDD for the deaf: (505) 841-6043

www.workerscomp.state.nm.us

Employer/employee: Each keep one copy.
Empleador/empleado: Retener una copia.

Form NOA-1-W (4/12)

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

KENNETH J. MUNNELLY, CHAIR/PRESIDENTE

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

ZURICH AMERICAN INSURANCE COMPANY
1299 ZURICH WAY
SCHAUMBURG, IL 60196-5870
800-987-3373

For Insurance Carriers ONLY: Policy No..... **WC 009015351-03**

Policy in Force from ..... **7/1/2017** *.....to .....* **7/1/2018**

Name of employer (Nombre del patrono)

EASTERN KENTUCKY UNIVERSITY

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

FORM 17

Revised 11/2014

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

The Employee Should:

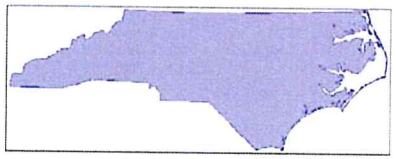
- Report the injury or occupational disease to the Employer immediately.
- Give written notice to the Employer within 30 days.
- File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.
- If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.
- Your employer's workers' compensation insurance carrier is ZURICH AMERICAN INSURANCE COMPANY.
- The insurance policy number is WC 009015351-03.
- Your employer's workers' compensation insurance policy is valid from 7/1/2017 until 7/1/2018.

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

- Provide all necessary medical services to the Employee.
- Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $2,000.00.
- Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.
- Ensure that compensation is promptly paid as required under the Workers' Compensation Act.

For assistance with Safety Education Training contact:
Director of Safety Education at (919) 807-2602 or safety@ic.nc.gov



NORTH CAROLINA INDUSTRIAL COMMISSION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335

Website: www.ic.nc.gov

TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat. §97-93).
POSTING LOCATION: [EASTERN KENTUCK] 521 LANCASTER AVE, ADAMS HOUSE, RICHMOND, KY 40475

Ohio | **Bureau of Workers' Compensation**

30 W. Spring St.
Columbus, OH 43215

Certificate of Ohio Workers' Compensation

This certifies that the employer listed below participates in the Ohio State Insurance Fund as required by law. Therefore, the employer is entitled to the rights and benefits of the fund for the period specified. This certificate is only valid if premiums and assessments, including installments, are paid by the applicable due date. To verify coverage, visit www.bwc.ohio.gov, or call 1-800-644-6292.

This certificate must be conspicuously posted.

Policy number and employer
01601822

EASTERN KENTUCKY UNIVERSITY
521 LANCASTER AVE-MATTOX HALL
RICHMOND, KY 40475-3100

Period Specified Below
07/01/2017 to 07/01/2018

www.bwc.ohio.gov
Issued by: WC

Administrator/CEO

You can reproduce this certificate as needed.

Ohio Bureau of Workers' Compensation

Required Posting

Effective Oct. 13, 2004, Section 4123.54 of the Ohio Revised Code requires notice of rebuttable presumption. Rebuttable presumption means an employee may dispute or prove untrue the presumption (or belief) that alcohol or a controlled substance not prescribed by the employee's physician is the proximate cause (main reason) of the work-related injury.

The burden of proof is on the employee to prove the presence of alcohol or a controlled substance was not the proximate cause of the work-related injury. An employee who tests positive or refuses to submit to chemical testing may be disqualified for compensation and benefits under the Workers' Compensation Act.

Ohio | **Bureau of Workers' Compensation**

You must post this language with the Certificate of Ohio Workers' Compensation.

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: EASTERN KENTUCKY UNIVERSITY

Date Posted: 7/7/2017

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company: ZURICH AMERICAN INSURANCE COMPANY

Address: 1299 ZURICH WAY
SCHAUMBURG, IL 60196-5870

Telephone Number: 800-987-3373

Insurer Code: _____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): ZURICH CLAIMS SERVICES

Address: PO BOX 49547
COLORADO SPRINGS, CO 80949-9537

Telephone Number: 800-987-3373

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured: _____

Address: _____

Telephone Number: _____

Insurer Code: _____

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator): _____

Address: _____

Telephone Number: _____

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
toll-free inside PA TTY: 800.362.4228
local & outside PA TTY: 717.772.4991

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

LIBC-500 REV 01-15

POSTING LOCATION: [EASTERN KENTUCK] 521 LANCASTER AVE., ADAMS HOUSE, RICHMOND, KY 40475

February 20, 2014

South Carolina Workers' Compensation

Workers' Compensation Compliance Poster

We are operating under and subject to the South Carolina Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

If you are injured on the job, you should:

1. Notify your employer at once. You cannot receive benefits unless your employer knows you are injured.
2. Tell the doctor your employer sends you to that you are covered by workers' compensation.
3. Notify the Workers' Compensation Provider listed on this poster or the South Carolina Workers' Compensation Commission at 803.737.5700 if you experience undue delays or problems with your claim.

South Carolina
Workers' Compensation Commission
P.O. Box 1715, 1333 Main Street, Suite 500
Columbia, S.C. 29202-1715
803-737-5700
www.wcc.sc.gov

Workers' Compensation Provider Name

ZURICH AMERICAN INSURANCE COMPANY

Mailing Address

1299 ZURICH WAY
SCHAUMBURG, IL 60196-5870

Claims Telephone Number

800-987-3373

POSTING LOCATION: [EASTERN KENTUCK] 521 LANCASTER AVE, ADAMS HOUSE, RICHMOND, KY 40475

TENNESSEE WORKERS' COMPENSATION INSURANCE POSTING NOTICE

The law requires this notice to be posted at the employer's place of business so all employees have access to it.

WHICH EMPLOYERS ARE COVERED BY THE TENNESSEE WORKERS' COMPENSATION ACT?

All employers with five (5) or more full or part-time employees, except as indicated below.
All employers engaged in the mining and production of coal with one (1) or more employees.
All workers in the construction industry unless they are specifically exempted.

WHAT SHOULD AN EMPLOYEE DO IF INJURED AT WORK?

1. Report the injury to the employer immediately;

2. Select a treating physician from a panel provided by the employer on the form described below. To report an injury contact:

ZURICH CLAIMS SERVICES

Name of employer representative to notify in event of a work related injury

800-987-3373

Telephone number of employer representative to notify in event of a work related injury

PO BOX 49547, COLORADO SPRINGS, CO 80949-9537

Address of employer representative to notify in event of a work related injury

3. If you have questions or problems, contact the Bureau as indicated below.

WHAT SHOULD AN EMPLOYER DO WHEN AN INJURY IS REPORTED?

1. Immediately complete a First Report of Work Injury form and send it to the workers' compensation insurance company or the third party administrator;
   AND,
2. Offer the employee a panel of physicians. The physicians must be provided on the official state form, which is the "AGREEMENT BETWEEN EMPLOYER/EMPLOYEE CHOICE OF PHYSICIAN —Form C-42." Additional instructions are available on the form. The form is available at:
   http://www.tn.gov/assets/entities/labor/attachments/c42.pdf

The Tennessee Bureau of Workers' Compensation has staff available to help both employees and employers. For more information contact:

TENNESSEE BUREAU OF WORKERS' COMPENSATION
220 FRENCH LANDING DRIVE, 1-B
NASHVILLE, TENNESSEE 37243-1002
615-532-4812 OR TOLL FREE 800-332-2667
800-332-2257 (TDD)
http://www.tn.gov/workforce/section/injuries-at-work

LB-0922 (REV. 7/15)
Authorization No. 337545
RDA 10183

WORKERS' COMPENSATION NOTICE THAT

Employer: **EASTERN KENTUCKY UNIVERSITY**
has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act by insuring with Insurance Carrier: **ZURICH AMERICAN INSURANCE COMPANY**
Policy Number: **WC 009015351-03**
Address for the above insurance carrier is **1299 ZURICH WAY, SCHAUMBURG, IL 60196-5870**
Telephone number is **800-987-3373**

WORKERS' COMPENSATION

IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICAL BILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury - no matter how slight - to your boss immediately. (You may lose your rights if your injury is not reported within 180 days of injury or work related illness.)

2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the Labor Commission and to the insurance company within seven (7) days of the accident.

3. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.

4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.

2. Ask your doctor to send a medical report to that insurance company.

3. Ask your employer to send a report of the accident to that insurance company.

4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation.

REHABILITATION

IF YOU CANNOT RETURN TO WORK, YOU MAY BE ELIGIBLE FOR A REHABILITATION PROGRAM – CALL YOUR INSURANCE CARRIER AS LISTED ABOVE.

FRAUD

"For your protection, Utah Law requires the following to appear on this form, any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

STATE OF UTAH
LABOR COMMISSION
160 EAST 300 SOUTH, PO BOX 146610
SALT LAKE CITY, UT 84114-6610
(801)530-6800 – (800)530-5090

If you want an Employee's Guide to Workers' Compensation or have questions, call the Labor Commission at the above listed numbers or go to our web page at www.laborcommission.utah.gov.

Note: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204 and §34A-2-104.5, Utah Code Annotated.

Revised 8/23/2016

POSTING LOCATION: [EASTERN KENTUCK] 521 LANCASTER AVE, ADAMS HOUSE, RICHMOND, KY 40475

VERMONT
DEPARTMENT OF LABOR

Employer's Liability and Workers' Compensation

NOTICE TO EMPLOYEES

This employer, EASTERN KENTUCKY UNIVERSITY, has complied with the provisions of Title 21 of the Vermont Statutes, Annotated §687, by obtaining Workers' Compensation Insurance coverage through:

ZURICH AMERICAN INSURANCE COMPANY
(Insurance Carrier)

Workers' Compensation benefits for lost time, medical expenses, disability or death because of a work-related injury are available through the above named company.

- An injured employee MUST immediately notify his/her employer of an injury.
- The employer MUST file an Employee Claim and Employer's First Report of Injury (Form 1) with the Vermont Department of Labor within 72 hours of the notice of an injury that requires medical attention or results in time lost from work. The employer must also provide a copy of the Form 1 to the injured worker and to the insurance carrier.
- If the employer fails to file a First Report, an employee may file a Notice of Injury and Claim for Compensation (Form 5) with the Vermont Department of Labor within six months of the date of injury.
- Information concerning injured worker rights and benefits is available on the department's Workers' Compensation website at http://www.labor.vermont.gov or by calling (802) 828-2286.

Equal Opportunity is the Law
The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711 (TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).

Form VWC1

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.

2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.

3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.

4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.

2. Report the injury to the Commission through your carrier or directly to the Commission.

3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, Virginia 23220

1-877-664-2566
vwc.state.va.us

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

POSTING LOCATION: [EASTERN KENTUCK] 521 LANCASTER AVE, ADAMS HOUSE, RICHMOND, KY 40475

NOTICE TO EMPLOYEES

WORKERS' COMPENSATION

Employer Name: EASTERN KENTUCKY UNIVERSITY

The above named employer, an employer within the meaning of the Workers' Compensation Law of the State of West Virginia, hereby gives notice to employees that the employer has secured the payment of Compensation to its employees and their dependents in accordance with the provision of said law, by insuring with:

Insurance Company: ZURICH AMERICAN INSURANCE COMPANY
1299 ZURICH WAY
SCHAUMBURG, IL 60196-5870
800-987-3373

Policy Effective Dates: 7/1/2017 to 7/1/2018

Policy Number: WC 009015351-03

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Claims Administered By: ZURICH CLAIMS SERVICES
PO BOX 49547
COLORADO SPRINGS, CO 80949-9537

Claims Representative:

Claims Telephone: 800-987-3373

Collecting Workers' Compensation benefits by intentionally misrepresenting, misstating, or failing to disclose any material fact is **fraud**. Fraudulent claims are subject to prosecution. All suspected violations will be investigated. Anyone may report a potentially fraudulent claim by contacting the Workers' Compensation Division or Attorney General's office.

POSTING LOCATION: [EASTERN KENTUCK] 521 LANCASTER AVE, ADAMS HOUSE, RICHMOND, KY 40475

Date Posted: 7/7/2017

NOTICE TO EMPLOYEES

WORKERS' COMPENSATION

Employer Name: EASTERN KENTUCKY UNIVERSITY

The above named employer, an employer within the meaning of the Workers' Compensation Law of the State of Wisconsin, hereby gives notice to employees that the employer has secured the payment of Compensation to its employees and their dependents in accordance with the provision of said law, by insuring with:

Insurance Company: ZURICH AMERICAN INSURANCE COMPANY
1299 ZURICH WAY
SCHAUMBURG, IL 60196-5870
800-987-3373

Policy Effective Dates: 7/1/2017 to 7/1/2018

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POSTING LOCATION: [EASTERN KENTUCK] 1340 OKEEFFE AVE APT 105, SUN PRAIRIE, WI 53590

Date Posted: 7/7/2017

NOTICE TO EMPLOYEES

WORKERS' COMPENSATION

Employer Name: EASTERN KENTUCKY UNIVERSITY

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POSTING LOCATION: [EASTERN KENTUCK] N 5152 SUMMIT DR, FOND DU LAC, WI 54937-9688

Date Posted: 7/7/2017