US SPECIALTY INSURANCE COMPANY

Dear Policyholder:

Welcome to U.S. Specialty Insurance Company! As the service provider for your Primary Employer Indemnity Program, we are committed to providing you with the highest quality of claims service available. We value our clients and view them as part of our team. Only by working together can we ensure that claims are handled thoroughly and expeditiously.

When injuries occur on the job, please report them immediately. You can send them by using our 24-hour claims reporting fax at 1-713-744-9675 or mail the reports to our office. Any urgent claim matters can be called in to us at 1-888-688-0775 or 1-713-744-3700. Claims and any related correspondence should be sent to our mailing address or to our E-mail address at: peiclaims@hcch.com

USSIC
Claim Department
13403 Northwest Freeway
Houston, TX 77040

Reports filed within 24 hours after the injury occurs will **reduce your deductible** up to $500.00 for each accident.

As participants in a Texas Admitted Non-Subscriber Program, your company is responsible for payment of claims directly to the injured worker and medical bill providers after we have determined that the claim is payable. Under this program, we will advance the reimbursement of all related medical bills subject to the re-priced amount. All bills are re-priced for Usual and Customary charges. Disability payments will be reimbursed once our office receives copies of the drafts issued to the injured worker by the employer. Your deductible is applied from first dollar, upon the receipt of either medical bills or disability payments, until it is satisfied. You will always receive a letter from us indicating what has been applied toward your deductible.

Always feel free to call us if there are any questions. U.S. Specialty Insurance Company looks forward to a long and pleasant working relationship with you.

Sincerely,

U.S. Specialty Insurance Company
Claims Department

A SUBSIDIARY OF HCC INSURANCE HOLDINGS, INC.

U S Specialty Insurance Company, Inc.

Accident Reporting Procedures

When an Accident (or alleged accident) occurs:

1. See that the injured employee received prompt medical attention.
    - Complete Employee Statement of Injury immediately upon notification of incident.
    - Complete initial Medical Treatment Authorization & Drug Alcohol Screen and send with employee to medical provider.
    - Send the employee to an approved occupational accident medical facility.

2. Obtain pertinent information about the claim.
    - To assist you with this, we suggest that you have the supervisor fill out a Supervisor's Incident Report.
    - Have all witnesses complete a Witness Statement.
    - **Please review the forms and make sure they are complete, signed and have your Policy number listed.**

3. Complete an injury report and mail or fax immediately to:

    U S Specialty Insurance Company, Inc.
    13403 Northwest Freeway
    Houston, TX 77040
    Fax: 713-744-9675

4. Accidents resulting in death or severe injury should be reported immediately by telephone. **Call 713-744-3700 or Toll Free 1-888-688-0775.**

5. After we have received the accident report, you will be contacted to assist us in the investigation of the claim.

Submitting medical bills:

Submit all medical reports and bills from medical care providers to U S Specialty Insurance Company, Inc.

If you should have any questions concerning a claim, do not hesitate to call us at 1-888-688-0775 between 8:30 am and 5:30 pm Monday through Friday, or e-mail us at peiclaims@hcch.com.

USSIC EMPLOYER REIMBURSEMENT

13403 Northwest Freeway, Houston, TX 77040

Please print or type form

FIRST REPORT OF INJURY

EMPLOYEE INFORMATION

Name			Gender		Social Security No.
Address		City	State	Zip	Phone
Date of Birth	Occupation	Department	Shift 1st ____ 2nd ____ 3rd ____		Date of Hire

INJURY DETAILS

Date of Injury	Time of Injury	Date Reported	Time Reported
Address Where Injury Occurred			
Was Employee Doing Regular Job?	Supervisor Name		
Description of Accident			
Description of Injuries/Part of Body			
Cause of Injury (Tool, Fall, Machine, etc.)			
Did the Injury Require Medical Care?			
Name of Medical Provider	Address		Phone
Name of Witness	Address		Phone
Name of Witness	Address		Phone
Date Disability Began	Date Return to Work	Rate of Pay Hourly $	Weekly $
Average Gross Weekly Wage (At least 12 weeks prior to accident, or number of weeks worked.)			

DOCUMENT ATTACHMENT (Required):
1) Signed Employee Acknowledgement of Summary Plan Description
2) Signed Authorization of Medical Treatment Document

POLICY INFORMATION

Employer Name	Policy #	Federal Tax Identification Number
Employer Address		Phone
Person Completing This Report		Date Completed

The employer agrees to make modified duty available for partially disabled employees able to return to some form of work as agreed to by their treating physician.

Employer Signature________________________________ Position ________________

Fax complete form to 713 744-9675 or call 888 688-0775

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USSIC EMPLOYER REIMBURSEMENT

13403 Northwest Freeway, Houston, TX 77040, *Facsimile: (713) 744-9675*

WAGE STATEMENT

Employee	Date of Injury	Claim No.
Employer	Date	

I have examined the payroll records for the employee listed above. The following table shows the weeks worked and the wages earned by the employee during the 52-week period prior to the injury or the actual number of week worked from date of hire; which ever is greater.

	WEEK ENDING			DAYS WORKED	GROSS WAGES		WEEK ENDING			DAYS WORKED	GROSS WAGES
WK#	MO	DAY	YR			WK#	MO	DAY	YR		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					

______________ ÷ ______________ = ______________ X 75% = ______________

TOTAL GROSS BENEFITS   NO. OF WEEKS   AVERAGE WEEKLY WAGE   DISABILITY BENEFIT

Preparer's Signature ______________________________ Date ______________

USSIC EMPLOYER REIMBURSEMENT

13403 Northwest Freeway, Houston, TX 77040

Employee Statement

Employer:____

Department/Division:______________________________________

Employee name:____
Last First Middle Initial

Phone( )__________

Address:______________________________
Street Apt. #

____
City St. Zip Code

Employee D. O. B.:______________ Social Security Number______________

Date of Injury:______________ Time:________ a.m.______ p.m.______

Accident Information

Where did Injury Occur?____________________________________

Describe Injury:____

____

Area of body injured:______________________________________

Witnesses: ______Yes ______No

Name(s): ____________________ ____________________

____________________ ____________________

Employee Job Title:______________________

Date reported to Supervisor:__________ Supervisor's Name:______________

Job being performed at time of Injury:______________________________

I certify this is a true and accurate report of the circumstances which occurred on the date of my injury stated above:

Signature of Injured Employee:______________date signed______________

Witness:__________________________date signed______________

USSIC **EMPLOYER REIMBURSEMENT**
13403 Northwest Freeway, Houston, TX 77040

MEDICAL AUTHORIZATION

You are hereby authorized to release to my employer any and all information, facts and particulars, which may be requested regarding my physical condition and/or treatment rendered to me and to permit my employer and any person appointed by my employer to examine all x-rays or records regarding my physical condition or treatment and to obtain copies of such records.

____________________________ ____________________________
Date Signature of Employee

AUTHORIZACION MEDICA

Usted esta autorizado de revelar a mi (Patron de Empleo) cualquier o toda informacion que le puedan puedan pedir sobre mi condicion fisica y tratamientas que sean de mi propiedad. Y permetir a mi (Patron de Empleo) o personas autorizadas bajo esta firma de empleo de examinar todos los documentos de rayos X. Y tratamienos fisicos y personales.

____________________________ ____________________________
Fecha Firma de empleo

OFFER OF MEDICAL TREATMENT DECLINED

I, ____________________________, declined medical treatment on this date

of __________________ for an injury sustained on the date of __________________.

I am aware that my employer, ____________________________________

will not be responsible for any medical expenses unless specifically approved by my

employer, ____

____________________________ ____________________________
Date Signature of Employee

USSIC EMPLOYER REIMBURSEMENT

13403 Northwest Freeway, Houston, TX 77040

WITNESS STATEMENT

Name of Company:______________________ Date of incident:__________________________

Name of Injured Employee:____

Name of Witness:____

Address:____ Phone #________________

Same employer as injured employee: ___________Yes ______________No

If not, employed by:_____________________________ Employer's Phone #________________

Are you related to the injured employee? ___________Yes ______________No

If "yes", how?____

How long have you known this employee:____

Please state the date:__________________ and time: ______________ of the injury.

Did you actually see this injury happen? : ___________Yes ______________No

If "no", how do you know about it?____

____

How near to the injured employee were you at the time of the injury?________________________

____

Please explain in detail what you know about this incident:______________________________

____

____

Did this employee ever talk with you about getting hurt on the job? _____Yes _____No

If "yes", when did this conversation take place?_____________Date ______________Time

What did the employee say?____

____

Do you know of any other injury, accident or illness this employee has had?

___________Yes ______________No If "yes", explain:____________________________

____

Give the names of any other persons who might know about this accident/injury:

_____________________________ ____

Additional comments:____

____

To the best of my knowledge, this statement is true and correct.

Signature of Witness:__________________________________ Date Signed:______________

USSIC EMPLOYER REIMBURSEMENT

13403 Northwest Freeway, Houston, TX 77040

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Work related or on the job incident/injury

Send this form to your companies main office, Manager, Risk Manager or designee within 24 hours

Employee Name:____

Date of incident__________________ Exact time of incident______________________________

Where did it happen____
(Incl. street address or department/location the employee was in at the time.)

List witnesses, addresses and phone numbers, including any persons that may have knowledge of the injury or incident, if known.

Name:______________________ Address______________________ Phone #____________

Name:______________________ Address______________________ Phone #____________

Did you take the employee to the doctor? __________Yes ____________No

Did the employee go to a doctor on own? __________Yes ____________No

Did the employee lose any work time due to the alleged injury i.e. unable to report to work for the next regular shift? __________Yes ____________No

List attending physician and or Hospital, if known.

Doctor Name:____________________Address____________________Phone#____________

Hospital Name____________________Address____________________Phone#____________

How long is the employee expected to be off work, if any?

Has the employee returned to work? ________Yes __________No (as of date of this report)

What happened? (describe fully what took place or what caused you to make this investigation.)

____

____

____

Exact date and time employee reported incident to manager/supervisor____________________

If not reported by injured employee, how did you learn of incident______________________

____

Name of the injured employee's immediate supervisor____________________ Phone #__________

Investigated by:____________________Title________________Date________Phone #________

Date this report was completed____________

Date this report was forwarded to company Management________________

______________________________ ______________________________

Signature of Employee | Person completing report