



# Owner Controlled Insurance Program (OCIP)



## **BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS**

# OCIP Insurance Manual

OWNER CONTROLLED INSURANCE PROGRAM

# Insurance Manual

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## Overview

Welcome to the Broward County Owner Controlled Insurance Program (OCIP)

The Risk Management Department, Broward County, Florida (Owner) has arranged for several airport, seaport, water & wastewater, and other departmental construction projects to be insured under an Owner Controlled Insurance Program (OCIP). An OCIP is a single insurance program that insures the Owner, enrolled Contractors and Subcontractors and other designated parties for Work performed at the Project Site(s). Certain Contractors are excluded from this Program. These parties are identified in Section 3 of this Manual.

An OCIP is a coordinated insurance program providing certain insurance coverages as generally described in this Manual for Work at the Project Site(s). Coverage under the OCIP includes Workers' Compensation, General Liability, and Excess Liability. The Owner is also providing Builder's Risk and Contractor's Pollution Liability.

The Owner will pay the insurance premiums for the coverages described in this Manual. You should notify your insurance broker/insurer(s) of the coverages provided under this Program for On-Site(s) activities to avoid duplication of coverage. **Each bidder is required to bid net of (i.e. to exclude) all insurance costs for all insurance coverages provided by the Owner.**

Excluded insurance costs are defined as insurance premiums, related taxes and assessments, overhead and markup on the insurance premiums, and losses retained through the use of a self-funded program, self-insured retention or deductible program. The Contractor must also exclude the cost of such insurance for all of their Subcontractors.

**NOTE:**

Insurance coverages and limits provided under the OCIP are limited in scope and are specific to work performed after the inception date of your enrollment into this program. Your insurance representative should review this information. **Any additional coverage you may wish to purchase will be at your option and expense.**

## OCIP Definitions

Contractors and Subcontractors of every tier shall **Bid Net of Insurance Cost** for coverage provided by the Owner under the Owner Controlled Insurance Program. In the bid, Contractor and Subcontractors of any tier must also remove the cost of insurance for their Subcontractors of any tier in addition to their own cost of insurance for coverages provided by the Owner under the OCIP.

A **Contract** is a written agreement between the Owner and the Contractor for specific work and also includes an agreement between a Contractor and any tier of Subcontractor.

A **Contractor** or **Subcontractor** is a person, firm, joint venture, corporation or other party that has entered into a Contract with either the Owner or their Contractor to perform Work at the Project Site(s).

A **Certificate of insurance** is a document providing evidence of the existence of coverage for a particular insurance policy or policies.

A **Confirmation Letter** is a letter issued by the OCIP Administrator that confirms acceptance of the applicant into the Broward County OCIP.

An **Employer** is any individual, firm, or corporation that provides direct construction labor for Work performed at the project Site(s).

### ***Enrolled Parties shall include:***

1. Owner, Owner's Representative, and any other party so named in the insurance policies; and
2. Eligible Contractors and Subcontractors of any tier whose employees will perform Work at the Project Site(s),
3. Any other party so designated by Broward County at the discretion of Broward County, Florida.

Enrollment in the program is **mandatory** for all Contractors and Subcontractors. Enrolled Parties shall obtain and maintain, and shall require each of their Subcontractors of any tier to obtain and maintain, the insurance coverage specified in Section 4.

### **Excluded Parties and Their Insurance Obligations.**

The OCIP Coverages do not cover the following "Excluded Parties":

1. Hazardous materials remediation, removal and/or transport companies and their consultants;
2. Architects, surveyors, and engineers, and soil testing engineers, and their consultants;
3. Vendors, suppliers, fabricators, and material dealers;
4. Truckers, haulers, drivers and others who merely transport, pick up, deliver, or carry materials, personnel, parts or equipment, or any other items or persons to or from the Project Site(s);

## O V E R V I E W

5. Contractors and each of its or their respective Subcontractors of all tiers who do not perform any actual labor on the Project Site(s); and
6. Any parties or entities not specifically identified in this Manual, or excluded by the Owner in its sole discretion, even if otherwise eligible.

Excluded Parties and parties no longer enrolled in, or covered by, the OCIP shall obtain and maintain, and shall require each of its or their Subcontractors of all tiers to obtain and maintain, the insurance coverage specified in Section 4 of this Insurance Manual.

The **Project Site(s)** includes the Ft. Lauderdale-Hollywood International Airport, Port Everglades, and other locations owned by Broward County. The Project Site(s) also include areas adjacent to or nearby the Project Site(s) where incidental operations are performed, excluding permanent locations of any insured party, other than the Owner's.

**Off Site(s)** locations are outside the boundaries of the Project Site(s) as shown above. Locations to be added to the Project Site(s), designated as "Off Site(s)" must be approved by the Owner and the Insurance Carrier prior to adding to the OCIP. All requests must be submitted to the Owner and OCIP Administrator.

The **Owner** and Sponsor of the OCIP is the Broward County Board of County Commissioners.

The **Project Site(s)** comprise the expected list of projects to be completed by the Owner under the OCIP. The project list is subject to change at the discretion of the Owner.

The **OCIP Administrator** is Aon Risk Services of Florida, Inc.

An **Owner Controlled Insurance Program (OCIP)** is a coordinated insurance program providing certain insurance coverages as generally described in this Manual for Work at the Project Site(s).

The **Work** is operations fully described in the Contract, performed at or emanating directly from the Project Site(s). Also, the entire completed construction project or the various separately identifiable parts described in the Contract documents are included for completed operations purposes.

## About This Manual

The Insurance Manual has been prepared by Aon Risk Services, Inc. of Florida (Aon) and Broward County, Board of County Commissioners (Owner). Aon is the insurance broker and **OCIP Administrator** for this Program. The Manual is designed to identify, define and assign responsibilities for the administration of the OCIP for the Broward County Owner Controlled Insurance Program.

### What This Manual Does

This Manual:

- Generally describes the structure of the Broward County OCIP;
- Identifies responsibilities of the various parties involved in the Program;
- Provides a *basic* description of OCIP coverages;
- Describes audit and administrative procedures of the program;
- Provides answers to basic questions about the OCIP;
- Is incorporated in the Contract Documents by reference and, therefore, forms part of the Contract for each enrolled Contractor and Subcontractor;
- Will be updated as necessary. The Broward County OCIP Insurance Manual may be updated during the course of construction to reflect any changes in State Rules and/or Regulations or Procedures that may be necessary, and said revisions shall replace all previous versions. Copies of any revised manual shall be posted online by the OCIP Administrator.

### What this Manual Does NOT DO

This Manual does not:

- Provide coverage interpretations;
- Provide complete information about coverages;
- Provide answers to specific claims questions;

Specific questions concerning the OCIP, its administration or insurance coverages provided, should be referred to the appropriate party identified in the Program Directory section immediately following this introduction.

**DISCLAIMER:** The information in this Manual is intended to outline the OCIP Program. If any conflict exists between this Manual and the OCIP insurance policies or Contracts between the Owner and the Contractor, the insurance policies or Contracts will govern.



## BROWARD COUNTY DIRECTORY

### Risk Management Division

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<b>Claims Department Fax Numbers:</b>		
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### Project Divisions

#### Aviation Department

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<b>Aviation Risk Insurance &amp; Contracts Manager</b>	Dawn Mehler	Phone: 954.359.6151 Email: <a href="mailto:dmehler@broward.org">dmehler@broward.org</a>

## Construction Management

**Project Manager** Steve Hammond      Phone: 954.357.7762  
Email:

## Parks and Receptions

Phone:  
Email:

## Port Everglades

**Port Administrator** John Fogelsong      Phone: 954.468.0142  
Email: jfogelsong@broward.org

**Security** Peter Hoffman      Phone: 954.468.0115  
Email:

## Transportation

Phone:  
Email:

## Water and Wastewater Services

**Water & Wastewater** Bob Leonard      Phone: 954.831.0969  
Email:

**Project Manager** Vin Morello      Phone: 954.831.0908  
Email:

Section  
3

## OCIP Insurance Coverage

*This section provides a brief description of OCIP Coverages. You must refer to the actual policies for details concerning coverage, exclusions and limitations.*

### Evidence of Coverage

The OCIP Administrator will provide a Certificate of Insurance evidencing workers' compensation, general liability, and excess liability insurance to each Enrolled Contractor and Enrolled Subcontractor, each of whom will be a named insured on the OCIP policies. A **Certificate of Insurance** is a document providing evidence of coverage for a particular insurance policy or policies. Other documentation including claim reporting forms, posting notices, etc., will be furnished to each Enrolled Contractor and Enrolled Subcontractor. Subsequent to enrollment, each enrolled Contractor and Subcontractor will be issued an individual Worker's Compensation policy.

Complete copies of policies will be furnished to an authorized representative of each enrolled Contractor and Subcontractor upon request.

### Description of OCIP Coverages

The following sections describe the policies that the Owner has arranged for the Program.

#### Workers' Compensation and Employer's Liability:

**State:** Florida

Limits of Liability

**Part One** - Workers' compensation:

**Part Two** - Employer's Liability:

Bodily Injury by Accident, each accident  
 Bodily Injury by Disease, each employee  
 Bodily Injury by Disease, policy limit

<b>Statutory Limit</b>
<u>Limits Per Insured</u>
\$1,000,000
\$1,000,000
\$1,000,000

Each enrolled Contractor and Subcontractor will be issued a separate Workers' Compensation policy.

A single policy will be issued covering all insureds.

Each Contractor Will Be Responsible For A **\$5,000.00** General Liability Obligation Per Occurrence For Any Claim Due To Contractor's Negligence As Shown In Its Contract Language For Any Damages/Injuries Caused By The Contractor Or Its Subcontractors To Third Parties. This is subject to change pending any formal changes to the construction agreement.

### Commercial General Liability

### Coverage Form-Occurrence

#### Limits of Liability

#### Shared by All Insureds

General Aggregate	\$4,000,000
Products/Completed Operations Aggregate	\$4,000,000
Bodily Injury & Property Damage—Each Occurrence	\$2,000,000
Personal/Advertising Injury—Each Occurrence	\$2,000,000
Fire Damage Legal Liability	\$500,000
Medical Expense	\$10,000

- Products & Completed Operations Extension: 10 Years
- This insurance will **NOT** provide coverage for products liability to any insured party, vendor, supplier, off-Site(s) fabricator, material dealer or other party for any product manufactured, assembled or otherwise worked upon away from the Project Site(s).
- **The policy contains exclusions.** Some of these exclusions are: Real & Personal Property in the care, custody or control of the insured; Asbestos; Lead; EFIS; Discrimination & Wrongful Termination; ERISA; Architects & Engineers Errors & Omissions; Owned & Non-Owned Aircraft, Watercraft, Pollution and Automobile Liability; Nuclear Broad Form Liability.

### Excess Liability

### Limits of Liability

#### Shared by All Insureds

Each Occurrence Limit	\$200,000,000
Annual General Aggregate Limit	\$200,000,000

- The Policies follow form (provisions, coverage, exclusions, etc.) of underlying Commercial General Liability and Employer's Liability policy wording.

### NOTE:

Contractors and Subcontractors are advised to arrange their own insurance for Contractor or Subcontractor owned or leased equipment and materials not intended for inclusion in the project. The OCIP will not cover Contractor or Subcontractor property.

## OCIP Termination or Modification

The Owner reserves the right to terminate or modify the OCIP or request that an Enrolled Contractor or Enrolled Subcontractor withdraw from the OCIP. If the Owner exercises this right, then Contractors will be given notice as required by the terms of their individual Contracts. At its option, the Owner may then procure alternate insurance coverage or the Owner may require Contractors to procure or maintain alternate insurance coverage. The

form, limits of liability and cost of such insurance and the insurer issuing such insurance to its Contractor or its Subcontractors will be subject to the Owner's approval.

## Description of Other Owner Provided Coverages

The following section describes additional policies that the Owner has arranged for the Project.

**For OCIP projects greater than \$30 million, Broward County will procure Builder's Risk limits on a per project basis commensurate with the project contract value.**

### **Builders Risk – Master Policy**

#### Master Builder's Risk

Builder's Risk or Course of Construction Insurance, insuring Risks of direct physical loss unless excluded. Coverage includes property in transit, property at temporary storage location, earthquake, windstorm, and flood (other than Zones A or V) and damage to existing property business interruption at Port Everglades and the Ft. Lauderdale Hollywood International airport, subject to applicable sub-limits and insuring the interests of Owner, Contractors, and their Subcontractors of any tier providing equipment, materials or services for the project. (Equipment is only covered if deemed to be incorporated as part of the project).

The Builder's Risk insurance will not provide coverage against loss by theft or disappearance of any materials (unless the materials are to be incorporated into the Project), tools, or equipment of the Contractor, Subcontractor of any tier or any other person furnishing labor or materials for the Work.

Value/Policy Limit: \$ 50,000,000 Property Damage, Each Occurrence

#### Coverage Extensions Sublimits:

a) Named Windstorm per occ.	\$50,000,000
b) Property Damage per occ.	\$50,000,000
c) Earth Movement annual aggregate	\$50,000,000
d) Flood annual aggregate	\$50,000,000
e) Debris Removal lesser of 25% of loss or	\$2,500,000
f) Property in Transit per occ.	\$250,000
g) Off-Site(s) Storage any one location per occ.	\$500,000
h) Ordinance or Law	\$2,500,000
i) Loss Adjustment Expenses per occ.	\$250,000
j) Valuable Papers and Records per occ.	\$250,000
k) Fire Dept. Services charges per occ.	\$100,000
l) Pollutant clean up annual aggregate	\$25,000
m) Combined Expediting Expenses and Extra Expenses	\$250,000

Each Contractor or Subcontractor will be responsible for a builder's risk deductible of \$25,000.00 per occurrence.

**CONTRACTOR and its Subcontractors of any tier each shall be responsible for a \$25,000.00 Builder's Risk deductible per occurrence for any claim**

**caused by Contractor or its Subcontractors during the course of construction.**

If arising out of direct damage to property under course of construction or installation, whether or not insured by OWNER for perils of flood and earth movement, Contractor and its Subcontractors of any tier each shall be responsible for the first \$25,000.00.

**Environmental/ Pollution Liability**

Each Contractor or Subcontractor will be responsible for a pollution liability deductible of \$50,000.00 per occurrence if accident/incident is due to their negligence.

Combined Single Limit per Occurrence \$200,000,000  
General Annual Aggregate \$200,000,000

**Contractor and its Subcontractors of any tier each shall be responsible for a \$50,000.00 contractor’s Pollution Liability deductible per occurrence for any claim caused by CONTRACTOR or its Subcontractors during the course of construction.**

**The descriptions on these pages provide a summary of coverage ONLY. Contractors and Subcontractors should refer to the policies for actual terms, conditions, exclusions and limitations.**

## CONTRACTOR OBLIGATIONS

**GENERAL LIABILITY OBLIGATION:** Each Contractor Will Be Responsible for A \$5,000.00 General Liability Obligation or the actual amount of the loss per occurrence up to \$5,000.00 for any claim due to Contractor's negligence as shown in its Contract language for any damages/injuries caused by the Contractor or its Subcontractors to third parties. This is subject to change pending any formal changes to the construction agreement. The Obligation will be charged to the negligent contractor and due to the Owner.

**BUILDER'S RISK DEDUCTIBLE:** Each contractor will be responsible for a \$25,000.00 deductible on any builder's risk claim due to contractor's negligence, including windstorm and flood. The Deductible will be charged to the negligent contractor and due to the Owner.

**POLLUTION LIABILITY DEDUCTIBLE:** Each contractor will be responsible for a \$50,000 deductible on any pollution liability claim due to contractor's negligence. The Deductible will be charged to the negligent contractor and due to the Owner.

### NOTE:

Insurance coverage and limits described in this Section are limited in scope and are specific to Work performed after the inception date of your enrollment into this Program. Your insurance representative should review this information. **Any additional coverage you may wish to purchase will be at your option and expense.**

## Contractor and Subcontractor Maintained Coverage Including Excluded Parties

*Enrolled Contractors and Enrolled Subcontractors are required to maintain insurance coverages to protect against losses that occur away from the Project Site(s) or that are otherwise not insured by the OCIP.*

See Section 8 for sample Certificate of Insurance.

Contractors and Subcontractors are required to maintain insurance coverage that protects the Owner from liability for claims for damages that may arise from the Contractor's and Subcontractor's operations performed away from the Project Site(s), from activities not insured by the OCIP, or from operations performed by Excluded Parties. There are two types of Contractors and Subcontractors: Enrolled Contractors and Excluded Contractors.

Enrolled Contractors are to provide evidence of Workers' Compensation and General Liability Insurance for **off-Site(s) activities** and Automobile Liability Insurance for both **on-Site(s) and off-Site(s) activities** as per the insurance specifications in the Contract. See Section 3 for the definition of an Enrolled Contractor.

Excluded Contractors must provide evidence of General Liability, Workers' Compensation and Auto Liability Insurance for all activities including **both on-Site(s) and off-Site(s) activities** as per the insurance specifications in the Contract. See Section 3 for the definition of Excluded Parties.

All Contractors must submit verification of insurance in the form of a **Certificate of Insurance** on a standard ACORD form 25-S. All Contractors must provide verification of insurance to the OCIP Administrator within ten (10) working days of award of contract, prior to mobilization, and within ten (10) days of any renewal, change or replacement of coverage. A sample of an acceptable Certificate of Insurance for Enrolled and Excluded Contractors and Subcontractors is provided in Section 8.

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Certificate of  
Insurance

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- Ten (10) days prior to mobilization and within ten (10) days of renewal, change or replacement of coverage, Contractors will submit to the Owner a Certificate of Insurance evidencing the coverage and limits as specified in this section.
- A 30-day notice of cancellation provision and additional insured status is required on all Certificates.

Please note the requirements for thirty (30) days notice of cancellation, modification or material change. The Additional Insured endorsement shall state that the coverage provided to the additional insureds is primary and non-contributory with respect to any other insurance available to the additional insureds.

All Contractors and Subcontractors are responsible for monitoring their Enrolled Subcontractors and Excluded Parties' Certificates of Insurance. The Owner reserves the right to disapprove the use of Contractors and Subcontractors unable to meet the program insurance requirements. Certificates of Insurance evidencing compliance are to be available to the Owner or the OCIP Administrator upon request.

The limits of liability shown for the insurance required of the Contractors and Subcontractors are minimum limits only and are not intended to restrict the liability imposed on the Contractors and Subcontractors for Work performed under their Contract.

**Enrolled**

Contractors shall provide evidence of workers' compensation insurance for **off-Site(s)** activities.

**Workers' Compensation and Employer's Liability**

**Part One - Workers' compensation:**

**Statutory Limit**

**Part Two - Employer's Liability:**

Bodily Injury by Accident, each accident	Annual Limits: \$1,000,000
Bodily Injury by Disease, each employee	\$1,000,000
Bodily Injury by Disease, policy limit	\$1,000,000

**Excluded**

Contractors shall provide evidence of workers' compensation applicable to **on and off-Site(s)** project.

**Commercial General Liability**

**Limits of Liability**

**Enrolled / Excluded**

General Aggregate	\$2,000,000/\$4,000,000
Products/Completed Operations Aggregate	\$2,000,000/\$4,000,000
Personal/Advertising Injury Aggregate	\$1,000,000/\$2,000,000
Each Occurrence Limit	\$1,000,000/\$2,000,000

**Enrolled**

Contractors shall provide evidence of general liability insurance for **off-Site(s)** activities.

Coverage must be an Occurrence form and it must apply to bodily injury and property damage for operations (including explosion, collapse and underground coverage), independent contractors, and products and completed operations. **Limits can be provided by a combination of a primary Commercial General Liability policy and an Excess or Umbrella Liability policy.**

**Excluded**

Contractors shall provide evidence of general liability insurance applicable to **on and off-Site(s)** projects and must add the Owner and other parties as additional insureds to their policy.

## Automobile Liability

All Contractors and Subcontractors shall provide evidence of on and off-site(s) automobile liability. The OCIP does not cover automobile liability.

A Commercial Business Auto Policy which covers all owned, hired and non-owned automobiles, trucks and trailers with coverage limits not less than **\$1,000,000 CSL for all projects other than airside projects at the Ft. Lauderdale Hollywood International Airport which require limits not less than \$5,000,000 CSL** each accident for bodily injury and property damage on-Site(s) and off-Site(s). **Limits are subject to change at the sole discretion of the Owner.**

## Property Insurance – Contractor’s Equipment

Contractor’s and Subcontractor’s are responsible for their own equipment. The OCIP does not provide coverage for Contractor’s Equipment.

Contractors and Subcontractors are advised to arrange their own insurance for owned and leased equipment, whether such equipment is located at a Project Site(s) or “in transit”. Contractors and Subcontractors are solely responsible for any loss or damage to their personal property including Contractor tools and equipment, scaffolding and temporary structures, whether owned, used, leased or rented by the Contractor. Contractors and Subcontractors are also responsible for any loss or damage to property or materials created or provided under the Contract until the property or materials arrive at the Project Site(s).

## Watercraft, and Aircraft Liability

The operator of any watercraft or aircraft of any kind must maintain liability naming the Owner and the respective Contractor and/or Subcontractors as additional insured with primary and non-contributory wording. In addition, the limit of liability must be satisfactory to the Owner. Such insurance requirements will be determined at the sole discretion of Owner as the need arises.

## Ocean Marine Liability (P&I)

All Contractors and Subcontractors must maintain an Ocean Marine Liability policy covering all owned, leased or hired and non-owned watercraft used in any fashion for such operations at or away from the Project Site and are not insured under the OCIP. Such coverage must extend to cover liability for bodily injury (including death) and property damage (including loss of use) with minimum combined limits of **\$1,000,000**. Such insurance shall be maintained in the form of a standard Protection and Indemnity policy which includes coverage for wreck removal, unlimited protection and indemnity, pollution liability and Jones Act exposures.

## Professional Liability

**BROWARD COUNTY** does not provide Professional Liability for Contractors and Subcontractors.

Professional Liability and Errors & Omissions Insurance will be the responsibility of the Contractor or Subcontractor. Professional Liability minimum requirement is \$2,000,000 per occurrence and \$4,000,000 aggregate.

### **Contractor's Pollution Liability**

Hazard remediation and demolition Contractors and Subcontractors whose Work involves removal or treatment of hazardous materials shall provide and maintain Contractor's Pollution Liability insurance that specifically schedules the type of Work to be done under contract.

Contractor's Pollution Liability insurance for Excluded Parties, with the following limits:

Combined Single Limit per Occurrence	\$2,000,000
General Annual Aggregate	\$2,000,000

If transporting hazardous waste/materials from the Project site, an appropriate MCS-90 Endorsement must be attached and supplied to COUNTY on a primary basis with \$5,000,000 limits of liability.

### **Additional Insureds**

The following shall be included as Additional Insureds as required by contract; this list may be updated at any time due to contractual requirements of the Owner.

**Broward County Board of County Commissioners (Owner), its commissioners, officers, directors, agents, employees, related entities, authorized representatives, servants, and assigns must be named as additional insureds.**

## Waiver of Subrogation

The Contractor's Workers' Compensation, General Liability, Umbrella or Excess Liability, Automobile, and Property insurers shall provide Waivers of Subrogation in favor of the Owner and other designated parties. Contractors and each of their Subcontractor's will similarly waive their rights of subrogation and recovery in each of their respective construction Contracts with respect to their work on this OCIP.

**Note: Waivers Required** - The Contractor's Workers' Compensation, General Liability, and Umbrella or Excess Liability, Automobile, Property and Contractor's Equipment insurers shall provide Waivers of Subrogation in favor of the Owner and other designated parties. General Liability and Excess Liability Insurance policies will name Broward County Board of County Commissioners (Owner), its commissioners, officers, directors, agents, employees, related entities, authorized representatives, servants, and assigns as additional insureds and shall state that coverage is primary and non-contributory.

## Contractor and Subcontractor Responsibilities

*Throughout the course of the OCIP, Contractors and Subcontractors will be responsible for reporting and maintaining certain records as outlined in this section.*

All Contractors and Subcontractors are required to cooperate with the Owner and its OCIP Administrator in all aspects of OCIP implementation, operation, and administration. Responsibilities of the Contractor and Subcontractors of any tier include all contract responsibilities, and the following:

- Enroll in the OCIP, if eligible, prior to mobilization;
- Provide timely evidence of other insurance or Owner required insurance to the OCIP Administrator prior to mobilization;
- Include OCIP provisions in all contracts with Subcontractors;
- Provide each Subcontractor with a copy of the Broward County OCIP Program Manual. The Broward County OCIP manual may be updated during the course of construction to reflect any changes in State Rules and/or Regulation or Procedures that may be necessary, and said revised and said revisions shall replace all previous versions. Copies of any revised manual shall be posted online by the OCIP Administrator;
- Notify the OCIP Administrator of all subcontracts, including lower tier subcontracts, awarded and/ or terminated;
- Maintain and report payroll records to the OCIP Administrator on a monthly basis;
- Cooperate with the OCIP Administrator's requests for information;
- Comply with insurance, claim and safety procedures as required by the Owner;
- Monitor its Subcontractor's Certificates of Insurance;
- Notify the OCIP Administrator immediately of any insurance cancellation, modification, material change or non renewal of Contractor required insurance.
- To ensure that coverage is in effect for all employees leased through an Employee Leasing Company (PEO) provide the leasing company's Name and Address at time of enrollment on the "Enrollment Application - Form 3". 1) If the Employee Leasing Company (PEO) changes mid-term, or 2) If the contract with the leasing company is terminated during the time period of enrollment in

the OCIP, or 3) If you contract a PEO mid-enrollment, **notify the OCIP Administrator immediately.**

### Responsibilities of Subcontractors of all tiers:

- Enroll in the OCIP, if eligible, prior to mobilization;
- Maintain and report monthly payroll records to the OCIP Administrator on a monthly basis;
- Cooperate with the OCIP Administrator's requests for information;
- Comply with insurance, claim, audit and safety procedures as required by Owner;
- Monitor its Subcontractor's Certificates of Insurance.

### Contractor Bids

See Section 2 for information on contacting the OCIP Administrator.

The Owner provides insurance for all eligible, Enrolled Contractors and Subcontractors under the OCIP for Work performed at the Project Site(s). The Owner will pay the insurance premiums for the coverages described in this Manual. You should notify your insurance broker/insurer(s) of the coverages provided under this Program for On-Site(s) activities to avoid duplication of coverage. **Each bidder is required to bid net of (i.e. to exclude) all insurance costs for all insurance coverages provided by the Owner.**

### Adjustments for OCIP Insurance Costs

Each Contractor and Subcontractor is required to **exclude** the cost of insurance that is provided by the Owner from its bid price for the proposed scope of work at the Project Site(s) (including subcontracted work whether or not the Subcontractor firm is identified at the time of the bid).

Under the OCIP, the final payroll is determined by an audit by the OCIP insurer or their representatives.

**Contractors are solely responsible for ensuring that their Subcontractors of all tiers also exclude the cost of insurance in their bid.**

### Change Order Procedures

Change orders should be priced by the Contractor and Subcontractor to **exclude** any costs of insurance for the coverages that are provided by the OCIP.

## Notice of Award

Contractors who utilize Subcontractors of any tier must complete and submit the Notice of Award form to the OCIP Administrator (Aon-A) to identify contracts awarded to Subcontractors of any tier who will perform labor at the Project Site(s); a sample is included in Section 8. This form must be completed and submitted to the OCIP Administrator prior to mobilization on the Project Site(s).

## Enrollment

Each Contractor and Subcontractor shall provide details about its Subcontractors to the OCIP Administrator, in order to enroll them in the OCIP. The Contractor and Subcontractor must complete and submit the Enrollment Application form to the OCIP Administrator (Aon-3); a sample is included in Section 8. This form must be completed and submitted to the OCIP Administrator prior to mobilization on the Project Site(s) to obtain coverage under the OCIP. **All Enrollment forms should be entered online, please see Section 7 of this Insurance Manual for details or contact your OCIP Administrator.**

Each Enrolled Contractor or Enrolled Subcontractor accepted into the OCIP will receive a **Confirmation Letter** and **Certificate of Insurance** from the OCIP Administrator. A **Confirmation Letter** is a letter issued by the OCIP Administrator that confirms acceptance of the applicant into the OCIP.

### Enrollment is not automatic

Enrollment into the OCIP is required, but not automatic. All Eligible Contractors and Subcontractors MUST complete the enrollment forms and participate in the enrollment process for OCIP coverage to apply. Access to the Project Site(s) will not be permitted until Enrollment into the OCIP is complete.

## Maintaining Enrollment in the OCIP

If you do not comply with all the terms of this Manual in a timely manner you may not remain enrolled in the OCIP. Contractors eligible for enrollment in the OCIP who are not enrolled in the OCIP will not be granted access to the Project Site(s).

## Assignment of Return Premiums

The cost of the OCIP insurance coverages will be paid by the Owner. The Owner will be the sole recipient of any return OCIP premiums or dividends. All enrolled Contractors and Subcontractors shall assign to Owner all adjustments, refunds, premium discounts, dividends, credits or any other monies due from the OCIP insurers. Contractors and Subcontractors shall assure that each Enrolled Subcontractor shall execute such an assignment. The Enrollment Form (Aon-3) supplied in Section 8 is used for this purpose.

See Section 8 for sample OCIP forms. No Contractor or Subcontractor will be granted access or allowed to perform work at a Project Site(s) until properly enrolled or specifically excluded from the OCIP.

All OCIP forms should be completed online at:  
<https://www.aonwrap.aon.com>

## Safety Standards

Safety Standards establish minimum standards for Contractor safety programs. Safety Standards are provided to all participants during the bidding process.

Each Contractor and Subcontractor is required to have a written safety program and to provide a designated safety representative who is on the Project Site(s) when any Work is in progress. Minimum standards for Contractor safety programs are outlined in the Broward County Safety and Loss Prevention Manual.

## Payroll Reports

Payroll Reports: Failure to submit the payroll reports as required may result in the withholding of payments until required documentation is received.

Each Enrolled Contractor and Subcontractor of every tier must submit monthly payroll reports to the OCIP Administrator. The reports will identify worker-hours and payroll by workers' compensation classification code for all Work performed at the Project Site(s). This information will be used to provide the Owner's insurers with information required for determining the Owner's premium.

All OCIP forms should be completed online at:  
<https://www.aonwrap.aon.com>

All Enrolled Contractors and Subcontractors must submit payroll reports prior to the 10<sup>th</sup> of the following month. The Monthly On-Site(s) Payroll Report form (Aon-4), provided in Section 8, is the appropriate form. A separate payroll report must be completed for each contract. The monthly worker-hour and payroll reports should include supervisory, safety and clerical personnel that are on-Site(s) and cover all Work performed at or emanating directly from each Project Site(s). **All payrolls should be entered online, please see Section 7 of this Insurance Manual for details or contact your OCIP Administrator.**

Earnings for overtime should be included only at the normal hourly rate (**DO NOT INCLUDE EXTRA WAGES, OR PREMIUM PORTION OF OVERTIME PAY, WHEN CALCULATING PAYROLL.** Overtime means those hours in excess of 8 hours worked each day, 40 hours in any week or on Saturdays, Sundays, or holidays, but only when there is an increase in the hourly rate to work such hours.

## Insurance Company Payroll Audit

Each enrolled Contractor and Subcontractor is required to maintain payroll records for Work at the Project Site(s). Such records shall allocate the payroll by Workers' Compensation classification(s) code and shall exclude the excess or premium paid for overtime (i.e., only the straight time rate shall apply to overtime hours Worked). Furthermore, such records shall limit the payroll for Executive Officers and Partners/Sole Proprietors to the limitations as stated in the State of Florida Manual Rules.

It is important to properly classify payrolls as these will be reported to the Rating Bureau for promulgation of future Experience Modifiers for your firm. All enrolled Contractors and Subcontractors shall make available their books, vouchers, contracts, documents, and records, of any and all kinds, to the auditors of the OCIP insurance carriers or Owner's representatives at any reasonable time during the policy period, any extension, or during a final audit period as required by the insurance policies.

## Close-Out and Audit Procedures

All OCIP forms should be completed online at:  
<https://www.aonwrap.aon.com>

Each Enrolled Contractor and Subcontractor must submit the Notice of Work Completion form (Aon-5), when a Contractor and/or a lower tier Subcontractor has completed its Work at the Project Site(s) and no longer has workers on Site(s) **(including Punch-List)**. The Aon-5 form will initiate the close-out process and audit of payroll and worker-hours by the OCIP Insurer(s). The ***OCIP Insurer*** is the insurance company named on the policy or on the Certificate of Insurance that provides coverage for the OCIP. A copy of the Notice of Work Completion form, (Aon-5) with instructions on the proper method for completion is found in Section 8. **All Notice of Work Completion forms should be entered online, please see Section 7 of this Insurance Manual for details or contact your OCIP Administrator.**

Issuance of final payment and/or project retainage will not be authorized by the Owner until all necessary forms have been submitted to the OCIP Administrator.

## Claim Reporting Procedures

*This section describes the basic procedures for reporting various types of claims: Workers' Compensation, General Liability, and damage to the Project.*

### Workers' Compensation Claims

Claims Kits will be available to all Contractors. It will include details about claim reporting and is intended for use at the Project Site(s).

In the event of an accident or injury, the main responsibility for any Contractor and Subcontractor is first to see that the injured worker receives immediate medical care. Local 911 emergency ambulance service should only be used in response to a serious traumatic life-threatening injury. Otherwise, injured workers' who require medical treatment must utilize one of the Owner's approved medical clinics indicated below.

Next, you should notify by phone, the following:

- The General Contractor's Safety Manager (See Directory, page )
- OCIP Safety Manager (See Directory, page 7)
- OCIP Administrator (See Directory, page 7)
- Risk Management – Charmaine Rivers, Worker's Compensation Manager Phone – 954.357.7230
- Risk Management – Barbara Bryant, Worker's Compensation Supervisor Phone – 954.357.5534

The below listed clinics should be utilized for all non-life threatening injuries and the primary care physician shall arrange and manage all follow up care. **The designated clinics for treatment of injured workers are:**

**Medwork84**

407 SE 24<sup>th</sup> Street (SR 84)  
Fort Lauderdale, FL 33316  
(954)467 2140

**Medstar**

3501 N. Federal Hwy  
Pompano, FL 33064  
(954) 785 5411

**Urgent Medical Care**

311 S Cypress Creek Rd  
Pompano, FL 33060  
(954) 781 7248

**Injured workers are advised to go to the nearest medical treatment facility/hospital emergency room for life threatening injuries.**

Contractors and Subcontractors must designate a representative at the Project Site(s) to take injured employees to the medical treatment center (clinic) and to report the claim. This individual is to remain with the injured employee at the medical treatment center while he/she is being treated. The treating physician should provide a written description of whether or not the injured employee can return to work, a list of restrictions if any, and the estimated length of time the injured worker must be on modified duty. The Owner supports transitional modified work to keep injured workers gainfully employed during recovery.

Copies of the treating physician's written description should be returned to the employee for his/her Employer, the OCIP Safety Manager, General Contractor's Safety Manager and OCIP Administrator. A post accident drug test will be included in the treatment regimen as indicated in the Program Safety Standards.

A detailed Broward County **Loss Notice** form (Exhibit 4, Section 8) must be completed along with the **FLORIDA DEPARTMENT OF FINANCIAL SERVICES DIVISION OF WORKERS' COMPENSATION FIRST REPORT OF INJURY OR ILLNESS form** (Form DFS-F2-DWC-1 (08/2004) (Exhibit 3, Section 8) and turned into the OCIP Safety Manager, OCIP Administrator, and General Contractor's Safety Manager within twenty-four (24) hours of the accident/incident.

Each Contractor and Subcontractor with employees injured at a Project Site(s) will be required to attend claims meetings and participate in the management of claims for their employees. Injured employees will cooperate with the OCIP Insurer and comply with the treatment regimen prescribed by the primary care physician.

When additional information is requested by the insurance carrier or the employer needs to talk to the adjuster:

## Liability Claims

Report all Liability claims to the OCIP Safety Manager & Administrator and the General Contractor's Safety Manager.

Incidents or accidents at, or around the Project Site(s) or a designated off-Site(s) location that has been added to the OCIP (see definition of *Project Site(s)* on page 2) resulting in damage to the property of others (other than your own property, rented or leased property, or your own Work product), or personal injury or death to a member of the public, must be reported immediately to the designated claims and safety representatives and OCIP Administrator. (See Section 2 for contact information). Contractors and Subcontractors must designate a representative at the Project Site(s) to report the claim.

A detailed Broward County **Loss Notice** form (Exhibit 4, Section 8) must be completed and turned into the OCIP Safety Manager, OCIP Administrator, and General Contractor's Safety Manager within twenty-four (24) hours of the accident/incident. This documentation will be forwarded onto the insurance carrier for further handling. A copy of this documentation should be sent to Sandy Steinlage, Risk Management Liability Supervisor, at [SSteinlage@broward.org](mailto:SSteinlage@broward.org) and Jacqueline Binns, Risk Insurance and Contracts Manager at [JBinns@broward.org](mailto:JBinns@broward.org).

Do *not* voluntarily admit liability. Contractors and Subcontractors of any tier must cooperate with the Owner and the OCIP insurer representatives in the accident investigation.

The insurance carrier will investigate, process, and settle each claim. **Each Contractor will be responsible for a \$5,000.00 (or other negotiated amount as shown in the Contract) general liability Obligation per occurrence for any claim due to Contractor's negligence as shown in its Contract for any damages/injuries caused by the Contractor or its Subcontractors of any tier to third parties.** This is subject to change pending any formal changes to the Contract agreement.

The Obligation will be charged to the negligent contractor and due to the Owner.

## Builder's Risk Claims

Report all Builder's Risk claims to the OCIP Safety Manager & Administrator, and the General Contractor's Safety Manager.

Report all incidents/accidents immediately. A detailed Broward County **Loss Notice** form (Exhibit 4, Section 8) must be completed and turned into the OCIP Safety Manager, OCIP Administrator, and General Contractor's Safety Manager within twenty-four (24) hours of the accident/incident. Contractors and Subcontractors must designate a representative at the Project Site(s) to report the claim. This documentation will be forwarded onto the insurance carrier for further handling. A copy of this documentation should be sent to Sandy Steinlage, Risk Management Liability Supervisor, at [SSteinlage@broward.org](mailto:SSteinlage@broward.org), and Jacqueline Binns, Risk Insurance and Contracts Manager at [JBinns@broward.org](mailto:JBinns@broward.org).

The insurance carrier will investigate, process, and settle each claim. **Contractor and its Subcontractors of any tier each shall be responsible for a \$25,000.00 Builder's Risk deductible per occurrence for any claim caused by Contractor or its Subcontractors of any tier during the course of construction.** This is subject to change pending any formal changes to the Contract agreement.

The Deductible will be charged to the negligent contractor and due to the Owner.

## Automobile Claims

Report all Auto claims to your insurance carrier, the OCIP Safety Manager & Administrator, and the General Contractor's Safety Manager.

***No insurance coverage is provided for automobile accidents/claims under the OCIP. It is the sole responsibility of each Contractor and Subcontractor to report accidents/claims involving their automobiles to their own insurers.***

However, all accidents occurring in or around the job Site(s) must be reported to the designated claims and safety representatives and OCIP Administrator. (See Section 2 for contact information). The accident will be investigated with regard to any liability arising out of the Project construction activities that could result in future claims (i.e., due to the conditions of the roads, etc.). Each Contractor and Subcontractor shall cooperate in the investigation of all automobile accidents.

## Pollution Claims

Report all Pollution claims to the OCIP Safety Manager & Administrator and the General Contractor's Safety Manager.

The Owner's OCIP policies may provide limited coverage for certain pollution conditions ***but only if the incidents are discovered and reported promptly in writing***. Report all incidents/accidents immediately. A detailed Broward County **Loss Notice** form (Exhibit 4, Section 8) must be completed and turned into the OCIP Safety Manager, OCIP Administrator, and General Contractor's Safety Manager within twenty-four (24) hours of the accident/incident. Contractors and Subcontractors must designate a representative at the Project Site(s) to report the claim. This documentation will be forwarded onto the insurance carrier for further handling. A copy of this documentation should be sent to Danielle French, Interim Director Risk Management at [dfrench@broward.org](mailto:dfrench@broward.org) and Jacqueline Binns, Risk Insurance and Contracts Manager at [JBinns@broward.org](mailto:JBinns@broward.org).

The insurance carrier will investigate, process, and settle each claim. **Contractor and its Subcontractors of any tier each shall be responsible for a \$50,000.00 Contractor Pollution Legal Liability deductible per occurrence for any claim caused by Contractor or its Subcontractors of any tier during the course of construction.** This is subject to change pending any formal changes to the Contract agreement.

**The Deductible will be charged to the negligent contractor and due to the Owner.**

## AonWrap Web Instruction

### Obtain a User ID & Password

Contact your Aon Program Administrator by either phone or email. Have the following information available:

- Name & Contract Information (*Phone, Fax & email address*)
- Company Name
- Contract Number
- Contract with

### How to Access the AonWrap Application



You can access AonWrap by entering <https://www.aonwrap.aon.com> in your Internet Browser. *Be sure to include the www in the address, failure to do so could cause your log on process to fail.*

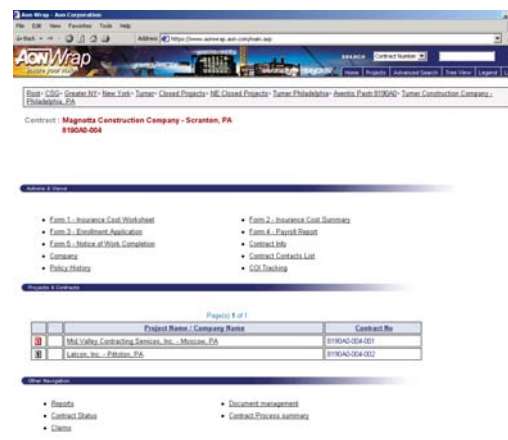
#### How to Login

Once at the AonWrap home page

- enter your unique User ID
- enter your Password
- Click on the **Enter** button to gain access to the secure AonWrap application
- Please note that the first time you log on you will be requested to change your password.

### Navigation

1. From the Welcome Page use the '► Browse Project' option in the left-section of the page.
2. Locate your project or contract in one of three available methods:
  - Use the  options to expand the tree view and select a project to begin working with. (sponsors only)
  - Drill down through project levels and contract relationships by clicking on the project or Contractor's name in the [Projects & Contracts](#) section, located in the middle of the screen.  The icon indicates that there is additional project or subcontract information.
  - The Search and Advanced Search options located in the screen header. (see *Search instruction for further details*)
3. Use the Location Bar and Project/Contract Description at the top of the screen to determine what information is presented



**Note:** Security features may prevent you from seeing all presented screens.

## How to Enroll on the Web (Aon Form-3)

1. Navigate to the contract and select the [Form-3 Enrollment Application](#) option.
2. Update your [Contractor Information](#) in section A. Modifications made in this will be posted to the database within 24 hours. *(The Federal ID number is required to enroll in the Wrap-up)*
3. Update [Contract Information](#) in section B of the Enrollment Application. *(Required fields include contract number, Estimated Start & Completion dates)*
4. Identify personnel from your company that are responsible for different pieces of information in Section C, [Contacts](#). Select the **Contacts** button. Follow the instructions in the [Update Contact Information](#) section of this pamphlet.
5. Enter your firm's estimated reportable payroll in the [Worker's Compensation Information](#) section (D) of the enrollment form screen.
  - If the desired WC class codes is listed, click in the **O** on the left column. Use the **Update** button to add the estimated man-hour and payroll information.
  - If the desired WC class code is not present, click the **Add** button. Enter the County, State, WC Class Code, estimated man-hours and payroll. *Please note, not all projects will allow the addition of new WC class codes. An error message will be displayed.*
  - Click on the **OK** button to record your information.

WC Class Codes can be entered using the numeric code or the [...] button can be used to search for a description.

6. Complete the [Off-Site\(s\) Workers Compensation Information](#) section (E).
  - Supply your firms Experience Modification information. Click in the **O** on the left column and use **Modify** button to change an existing entry. Use the **Add** button to create a new line of information. *(Information must be supplied for each state work will be performed in.)*
    - a) *The Bureau File # is also referred to as the Risk ID #. This information can be located on your experience modification worksheets.*
    - b) *If your company has been in business for less than 3 years, enter the following information: Bureau File # = New Company ; Experience Modification Factor = 1.00 Anniversary Rating Date and Effective Date of Modification Factor = First day your company was in business*
  - Enter the information relating to your existing workers' compensation carrier. Supply the carrier's full name of the insurance carrier *(no abbreviations)*, Policy number and Effective & Expiration dates
7. Identify any [Subcontractor Information](#) in section F. If you will not be using subcontractors, leave this section empty. Use the **Add** button to add a subcontractor. Verify your work by ensuring your own self-performed work plus the total Subcontract \$ amounts equal the expected Contract Amount on your contract.
8. The [Enrollment Questions](#) section G may pertain to your work at this project.
  - Check the boxes that describe your labor force and use of Aircraft & Watercraft. Your responses should only pertain to work performed under this contract on this project.
  - Additional project specific questions may be defined in the Optional Questions box. Answer any questions that may appear here.
9. If your firm has off-Site(s) storage facilities that are dedicated 100% for the storage of material for the specified project, record this information in the [Off-Site\(s\) Storage \(100% Dedicated\)](#) section. Use the **Add** button to add a line of information. Use the **OK** button to save work. Add as many lines of information as needed.

10. Type your name in the space provided and date the form. Your typed signature constitutes an electronic signature
11. Once you have completed everything and checked through your work:
  - When your information is ready to be processed, check the **Save and Notify Aon** indicator box.
  - **Save and Submit Later** allows you to save your work and return later to finish.
  - **Cancel** your work OR
  - **Print** your work

## How to Report Payroll (Aon Form-4)

1. Navigate to the contract and Click on the [Form 4 – Payroll Report](#) option located in the [Actions and Views](#) section of the page.
2. The Payroll list screen will display all types of payroll (missing, incomplete and completed) records. *If you are delinquent in submitting your payroll information, select the missing payroll record with the appropriate period ending date.*
3. Click on the **Open** button at the top of the screen to open an existing record or **New** button to create a new entry. Modify the payroll period dates if necessary.
4. Select the WC class code by clicking the ' ' in the left most column. Use the **Update** button to begin the modification process. Enter the man-hours and payroll information. If your WC class code is not present use the **Add** button.



*Note a: Some Projects will also require the entry of a purchase order number. This requirement will be displayed in a separate column.*


*Note b: Submit one payroll report per reporting period. Each payroll report can contain only one entry per class code unless a purchase order number is required.*

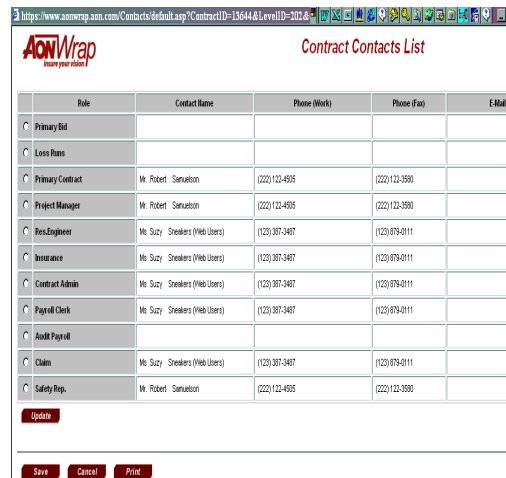
5. When you are finished click on the **OK** button to add the information.
6. If this project collects optional data it will be defined in the [Optional Fields](#) section. Enter information if specified.
7. Enter your name and date.
8. Once you have completed everything and checked through your work:
  - When your information is ready to be processed, check the **Save and Notify Aon** indicator box.
  - **Save and Submit Later** allows you to save your work and return later to finish.
  - **Cancel** your work OR
  - **Print** your work

## How to Submit a Notice of Work Completion (Aon Form-5)

1. Navigate to the contract and Click on the [Form 5 – Notice of Work Completion](#) option located in the [Actions and Views](#) section of the page.
2. Enter your name and date the form.
3. Request the sponsor or entity you contract with to approve the form. Your company cannot complete the approval.
4. Once you have completed everything and checked through your work:
  - When your information is ready to be processed, check the **Save and Notify Aon** indicator box.
  - **Save and Submit Later** allows you to save your work and return later to finish.
  - **Cancel** your work OR
  - **Print** your work.


## Contract Contact List

1. Click on the [Contract Contact List](#) option located in the [Actions and Views](#) section of the page.
2. Select the 'Role' to add, update or modify by clicking on the ' ' to the left most column.
3. Click the **Update** button to proceed with additions or modifications to the information.
4. Use the dropdown box in the Contact Name column to select an existing entry. Click **OK** to save this name as the contact.
5. If the Name does *not* exist in the available options, use the **New** button to create a new contact. Be sure to provide the
  - Individual's Name (Prefix, first, middle & last name)
  - Phone & Fax Number (*enter without special characters ( , ) or -*)
  - Address Line 1, Address Line 2, City, State and Zipcode
  - Optional fields include a Phone (Work 2), Phone (Cell), Phone (Pager), Phone (Home 1) and Phone (Home 2). (*Do not include special characters in all phone numbers*)
  - To save your work, click on the **OK** button.
6. If the Name exists in the available options but information requires revision, use the **Modify** button to change the contact's information.
  - Change the information.
  - Select the **OK** button to save your work
7. Repeat the steps above until all desired contacts are identified.
8. Use the **Save** button to save your work.
9. Use the  on the upper right hand corner to close the screen.




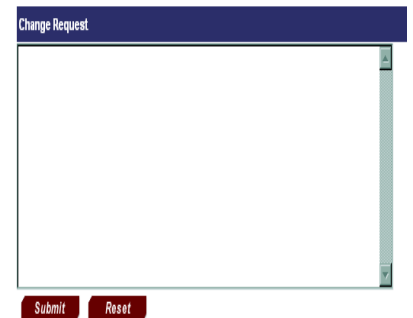
Role	Contact Name	Phone (Work)	Phone (Fax)	E-Mail
Primary Bid				
Loss Plans				
Primary Contract	Mr. Robert Samuelton	(222) 122-4935	(222) 122-3580	
Project Manager	Mr. Robert Samuelton	(222) 122-4935	(222) 122-3580	
Res.Engineers	Ms. Suzy Sreakers (Web Users)	(123) 307-3487	(123) 879-0111	
Insurance	Ms. Suzy Sreakers (Web Users)	(123) 307-3487	(123) 879-0111	
Contract Admin	Ms. Suzy Sreakers (Web Users)	(123) 307-3487	(123) 879-0111	
Payroll Clerk	Ms. Suzy Sreakers (Web Users)	(123) 307-3487	(123) 879-0111	
Asst Payroll				
Claims	Ms. Suzy Sreakers (Web Users)	(123) 307-3487	(123) 879-0111	
Safety Reps.	Mr. Robert Samuelton	(222) 122-4935	(222) 122-3580	

## Revise Company Information (i.e. change address)

1. Navigate to the contract and Click on the [Company](#) option located in the [Actions and Views](#) section of the page.
2. Modify the Company Information (*federal ID number, company name, address, phone and fax information*) as presented on the screen.
3. Press the **Add** button under the [WC General](#) section. Insert the Country, State, Bureau File # (*also known as the Risk ID Number*) and Anniversary Rating Date (*mm-dd format required*). Use the **OK** button when entry is complete
4. Use the **Submit** button to forward your changes to the administration staff. Please note that changes recorded in this section of the database will *not* automatically be posted to the database. An action will be created for the administration staff to update your records.
5. After Submission of your changes, return to the main page by closing the screen. Use the  on the upper right hand corner of the screen.

## Update Contract Information

1. Navigate to the contract and Click on the [Contract Info](#) option located in the [Actions and Views](#) section of the page.
2. Review the information in the [Contract](#) Section of the screen (*Bid & Contract Number, Bid Due Date, Contract Award Date, Work Description, Contract Amount, Amount of Self-Performed and estimated & actual contract start and completion dates*). In the [Change Request](#) section identify any correction or updates to the information. Also include the name of any subcontractors, address, contact name and phone number.
3. Use the **Submit** button to forward your changes to the administration staff. Please note that changes recorded in this section of the database will *not* automatically be posted to the database.
4. After Submission of your changes, return to the main page by closing the screen. Use the  on the upper right hand corner of the screen.



## Complete and/or updated Web Instructions

Complete and/or updated Web Instructions are available on the web page. To locate, click on the [Document Management](#) option in the [Other Navigation](#) section of the screen.

1. Click on the [Reference Material](#) category.
2. Click on the [Web Instructions](#) Document Name to download or view the document.

## Forms

*This section contains the forms needed for reporting claims, reporting payroll and administration of the OCIP. Aon Forms 3-5 should be reported on-line at: <https://www.aonwrap.aon.com>*

This section contains the following forms:

Aon Form-3	Enrollment Application
Aon Form-4	Monthly On-Site(s) Payroll Report
Aon Form-5	Notice of Work Completion
Aon Form-A	Notice of Award
Exhibit 1	Sample Certificate of Insurance – Enrolled Contractors and Subcontractors
Exhibit 2	Sample Certificate of Insurance – Excluded Contractors and Subcontractors
Exhibit 3	Workers' Compensation Claim Form
Exhibit 4	Broward County Loss Notice

**Note:**

For assistance in completing these forms, please contact the Insurance Administrator listed below:

**Aon Risk Services – Roshunda Parker , Program Administrator**

**Phone: 954.926.5148**

**Fax: 954.926.5149**

**Email: [Roshunda.parker@aon.com](mailto:Roshunda.parker@aon.com)**

Numbers reference attached instructions

Examine your current Workers' Compensation and General Liability Policies or contact your Insurance Agent to assist you with completing this form. **\*\*\* NOTICE \*\*\*** Enrollment is not automatic and requires the satisfactory completion of the Aon Form-1a or Form-1b, Form-2 and Form-3. In addition, submit a Certificate of Insurance providing evidence of your *off-Site(s)* coverage. Please refer to the Insurance Manual for coverage requirements.

**A. Contractor Information:**

Federal ID # or Soc. Sec. #: <sup>1</sup> \_\_\_\_\_

▼ **Business Information (headquarters)**

▼ **Contact Information (address questions to..)**

Company Name & dba: <sup>2</sup> \_\_\_\_\_  
 Contact Name & Title: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City, State Zip Code: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

<sup>3</sup> \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Indicate your Organization's Structure: <sup>4</sup>  Corporation  Partnership  S-Corporation  
 Joint Venture  Sole Proprietor  Other \_\_\_\_\_

**B. CONTRACT INFORMATION:**

Contract No.: <sup>1</sup> \_\_\_\_\_

**BROWARD COUNTY**

Date Contract Awarded: <sup>2</sup> \_\_\_\_\_

Description of Work: <sup>3</sup> \_\_\_\_\_

Proposed Contract Price \$: <sup>4</sup> \_\_\_\_\_ Are you Submitting a bid to **BROWARD COUNTY** <sup>6</sup>  Yes  No

Amount of Self Performed Work \$: <sup>5</sup> \_\_\_\_\_ If No, identify to whom: <sup>7</sup> \_\_\_\_\_

Start Date: <sup>7</sup> \_\_\_\_\_  Actual  Estimated Completion Date: <sup>8</sup> \_\_\_\_\_  Actual  Estimated

**C. Contacts: (Complete if Applicable)**

Position	<sup>1</sup> Name & Title	<sup>2</sup> Phone	<sup>3</sup> Fax	<sup>4</sup> email address
Project Mgr:				
Res. Engineer:				
Insurance:				
Contract Admin:				
Payroll:				
Claims:				
Safety Rep:				

Provide Location of payroll records if different than Corporate address: <sup>5</sup> \_\_\_\_\_ Phone: \_\_\_\_\_  
 City, State, Zip Code: \_\_\_\_\_ Fax: \_\_\_\_\_

**D. Workers' Compensation Insurance Information for Work Described Above: (attach a separate sheet if necessary)**

a State	b Class Code	c Description	d Man-hours	e Payroll
<sup>1</sup>				
<b>Totals</b>			<sup>2</sup>	<sup>3</sup>

**E. Provide your current Off-Site(s) Workers' Compensation Information: (for each state you will perform work in)**

Applicable State	Risk ID Number	Rating Bureau	Anniversary Rating Date
<sup>1</sup>	<sup>2</sup>	<sup>3</sup>	<sup>4</sup>

Your WC Insurance Carrier: <sup>5</sup> \_\_\_\_\_  
 Policy #: <sup>6</sup> \_\_\_\_\_ Effective Date: <sup>7</sup> \_\_\_\_\_ Expiration Date: <sup>8</sup> \_\_\_\_\_

**F. Subcontract Information:** List all Subcontractors that will be working for you on this project (complete the information in the following table). Use additional paper if necessary:

1 Subcontractor	2 Subcontract \$	3 Contact Person	4 Address	5 Phone Number	6 Estimated Start Date

**G. Enrollment Questions:** Answer each question. Use additional paper if necessary.

- 1 Will you have any off-Site(s) location(s) 100% dedicated to this project?  Yes  No If yes, please provide address:  
\_\_\_\_\_
- 2 Please check if:  Any aircraft used on this project  Any watercraft used on this project
- 3 Please indicate if labor from the following sources will be used:  Employee Leasing Firm  Temporary Labor Agency
- 4 Employee Leasing Company Name? \_\_\_\_\_
- 5 Employee Leasing Company address? \_\_\_\_\_
- 6 Employee Leasing Company City, State and Zip? \_\_\_\_\_
- 7 What is your firm's Worker's Compensation Experience Modifier (EMR)? \_\_\_\_\_

**H. WARRANTY APPLICABLE TO PROGRAM INSURANCE COVERAGE**

- 1 Premiums for this Program are the responsibility of **BROWARD COUNTY** and I agree any and all return of premium, dividends, discounts, or other adjustments to any Program policy(ies) is assigned, transferred and set over absolutely to **BROWARD COUNTY**. This assignment applies to the Program policy(ies) as now written or as subsequently modified, rewritten or replaced. Rights of Cancellation for all Program insurance policy(ies) arranged by **BROWARD COUNTY** are assigned to **BROWARD COUNTY**.
- 2 I will pay the cost of premium(s) for non-Program insurance coverage, specified in the Contract Documents.
- 3 I authorized the release of all claim information for all insurance policies under this Program.
- 4 It is my responsibility to notify my insurance carrier(s) that I am en in this Program.
- 5 I have omitted from my bid the insurance costs for the coverage provided by **BROWARD COUNTY**. I further agree to the Aon Verified Insurance Cost Rate as described in the Insurance Manual.
- 6 The statements in this insurance application are true to the best of my knowledge.

**I. Signature Block :** I verify the information presented above and attachments are correct:  
 Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 (please print)  
 Title: \_\_\_\_\_ Signature: \_\_\_\_\_

**Note:** Information can be submitted on-line at [www.aonwrap.aon.com](http://www.aonwrap.aon.com). Please contact your Administration Staff to obtain a user ID and Password.

Fax or Mail to: Roshunda Parker  
 Aon Risk Services, Inc. of Florida  
 550 NW 10th Street  
 Danie, FL 33004

Phone: 954.926.5148  
 Fax: 954.926.5149  
 Email: Roshunda.parker@aon.com

This form must be completed and submitted by each successful Contractor and Subcontractor of any tier prior to Site(s) mobilization for each contract awarded. The Contractor and Subcontractor will submit the completed form to Aon Risk Services. Upon receipt of this form, Aon will issue to the Contractor or Subcontractor a Certificate of Insurance evidencing coverage in the Controlled Insurance Program. The completed Certificate of Insurance and Workers' Compensation insurance policy will be mailed to the Enrolled party.

**A. Contractor Information**

- 1 Enter your company's Federal ID number. This number can be found on filings made to the federal government such as your tax return.
- 2 Enter your company's name, mailing address and phone/fax number for your company's primary office location.
- 3 Enter the name of the person Aon should contact if questions arise. Include mailing address, phone/fax and email address, if different than A2.
- 4 Identify your company's legal structure by checking the box that applies. If the correct legal structure is not specifically listed, please check the "Other" box and specify in the space provided.

**B. Contract Information**

- 1 Enter the Contract Number or Purchase Order Number that was included in BROWARD COUNTY's originating documentation.
- 2 Supply the Date this Contract was awarded to your organization.
- 3 Provide a brief description of the work you will be performing at the project Site(s).
- 4 Identify the total amount of your contract.
- 5 Identify the amount of work that you anticipate will be self-performed.
- 6 Check the appropriate box that identifies if you contract directly with BROWARD COUNTY or are a Subcontractor.
- 7 If you are a Subcontractor, identify the entity with whom you are under contract.
- 8 Enter the Date you anticipate starting work and then mark whether the date provided is actual or estimated.
- 9 Enter the Date you anticipate completing the described work and then mark whether the date provided is actual or estimated.

**C. Contacts** *(Requested Contact information is for specific functions. It is possible to have a single person fulfill multiple responsibilities.)*

- 1 Identify the name of the person and their title for each function. These individuals should be located, if at all possible, on-Site(s).
- 2 Provide the phone number for each person identified above.
- 3 Provide the fax number for each person identified above.
- 4 Provide the email address for each person identified above, if applicable.
- 5 Identify the physical location where your payroll records are retained. Provide the Address, City, State, Zip Code, Telephone, Fax Number and Email Address of the person responsible for maintaining the payroll information.

**D. Workers' Compensation Information** *(Duplicate or attach additional sheets if necessary. You may create an electronic version of this document if all requested information is included.)*

- 1 a Enter the two letter abbreviation for the state in which the work will be performed.
- b Enter each Workers' Compensation class code that applies to the work identified in B2. (Most states use a 4 digit Number)
- c Enter the Workers' Compensation class code description that applies to the work identified in D1b.
- d Enter the estimated Man-hours required to complete the described work by Workers' Compensation class code.
- e Enter the estimated Payroll required to complete the described work for each Workers' Compensation class code. Use only unburdened payroll and exclude the premium portions of any overtime pay.
- 2 Total all estimated Man-hours for each class code. Be sure to include information from additional pages if used.
- 3 Total all estimated Payroll for each class code. Be sure to include information from additional pages if used.

**E. Current Off-Site(s) Workers' Compensation Information** *(Information relates to your corporation's existing coverage; identify each modification factor that applies.)*

- 1 Enter the State that the Modification Information applies to.
- 2 Enter your Bureau File Number also referred to as your Risk Identification Number. This number can also be found on your Modification worksheets.
- 3 Enter the Bureau Rating Agency. In most states this is NCCI.
- 4 Provide your Company's Anniversary Rating Date. Information can be located on your bureau's WC Experience Modification worksheets.
- 5 Identify your insurance carrier for Workers' Compensation Coverage.
- 6 Provide your Workers' Compensation Policy Number.
- 7 Provide the effective date of your Workers' Compensation policy.
- 8 Provide the expiration date of your Workers' Compensation policy.

**F. Subcontractor Information** *(Provide the following information for each Subcontractor that will be performing work at the project Site(s). Use additional sheets, if necessary.)*

- 1 Identify the name of the Subcontracting firm.
- 2 Provide the estimated value of the subcontracted activity.
- 3 Provide a contact name, preferably the project manager, for the Subcontractor.
- 4 Provide the mailing address for the Subcontractor.
- 5 Provide the phone number for the Subcontractor.
- 6 Provide the date the Subcontractor is scheduled to begin work.

**G. Enrollment Questions**

- 1 Determine if you will have any locations, off-Site(s), that will be 100% dedicated to this project. Include material/supply storage as a possible location. Mark the appropriate box (yes/no). If you answer yes – provide the address of each location you identified as 100% dedicated.
- 2 Mark the box or boxes that apply. Contemplate only work performed under this contract.
- 3 Mark the box or boxes that apply. Employee Leasing Firm are those firms that supply the labor force for your company *(You direct the activities of the Leasing Company's employees)*. Temporary Labor Firms supplement your labor force.

**H. Warranty Statements:**

- 1-6 Read each Warranty statement thoroughly. If you have questions regarding any of these statements, contact the Aon administrator identified on page 2.

**I. Signature Block:** This form must be signed by a representative of your company knowledgeable of its accuracy.

Forward the completed Enrollment Application to the Aon administrator identified at the bottom of page 2 of this form. The administrator prior to the start of your work on-Site(s) must receive this form.

Complete a Separate Form for Each Contract with **BROWARD COUNTY**.  
 Your report is due to the Aon Insurance Administrator, identified below, no later than the 10<sup>th</sup> day of the succeeding month.  
 Complete this report even though no work was performed; enter zero (0) for the Reportable Payroll.  
 Delay in providing this report may result in payments being withheld.

**A. REPORT IDENTIFICATION**

Period Beginning: <sup>1</sup> \_\_\_\_\_ Period Ending: <sup>2</sup> \_\_\_\_\_ Year: <sup>3</sup> \_\_\_\_\_  
 Contractor: <sup>4</sup> \_\_\_\_\_  
 Under Contract with: <sup>5</sup> \_\_\_\_\_  
 Contract #: <sup>6</sup> **BROWARD COUNTY**

**B. ACTIVITY REPORT**

a State	b Workers' Comp. Class Code	c Work Description	d Man-Hours	e Gross Payroll	f Reportable Payroll *
1					
<b>TOTALS:</b>			<sup>2</sup>	<sup>3</sup>	<sup>4</sup>

\* Do not include premium (excess) overtime wages, use straight time wage rates only. You must also comply with all rules set forth by the Workers Compensation Bureau in the state in which the work is performed.

**C. ADDITIONAL DATA REQUIREMENTS :**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**D. Signature Block :** I verify the information presented above and attachments are correct:

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 (please print)  
 Title: \_\_\_\_\_ Signature: \_\_\_\_\_

CHECK IF THIS IS YOUR LAST PAYROLL REPORT. COMPLETE AN AON FORM-5 "NOTICE OF WORK COMPLETION" AND INCLUDE WITH THIS PAYROLL REPORT.

**Note: Information can be submitted on-line** at [www.aonwrap.aon.com](http://www.aonwrap.aon.com). Please contact your Administration Staff to obtain a user ID and Password.

Fax or Mail to: Roshunda Parker  
 Aon Risk Services, Inc. of Florida  
 550 NW 10th Street  
 Danie, FL 33004

Phone: 954.926.5148  
 Fax: 954.926.5149  
 Email: roshunda.parker@aon.com

The Contractor and every Subcontractor of any tier performing work at the Project Site(s) for each Contract awarded must complete this form each month. The Contractor/Subcontractor must attach the completed report to their monthly pay request in order to receive interim payment. Contractors will be responsible for the submission of this form by their Subcontractors. Aon Risk Services can forward a supply of these forms to your company upon request.

**A. Report Identification**

- 1 Fill in the month and day for the beginning of the period you are reporting on.
- 2 Fill in the month and day for the ending of the period you are reporting on.
- 3 Fill in the year that applies to the reporting period.
- 4 Enter the name of your firm.
- 5 If you are a Subcontractor, identify the name of the firm you are contracted to. If you are a Prime Contractor enter N/A
- 6 Provide your Contract Number

**B. Activity Report**

- 1 For each Workers' Compensation Class Code that applies to work performed during the reporting period, provide the following information:
  - a Identify the state in which the work was performed.
  - b Identify the Workers' Compensation Class Code that applies to the work performed during the period. (Most states use a four digit No.)
  - c Provide a brief description of the work by class code.
  - d Identify the number of Man-hours worked by your employees for each applicable class code.
  - e Provide the Gross Payroll paid to your employees. This should include overtime pay and vacation pay.
  - f Determine the Reportable Payroll. Reportable Payroll does not include the premium portion of any overtime pay (i.e. 45 hours X \$10.00/hr = 450.00 *do not include the premium overtime pay of \$5.00 for the 5 hours of overtime*)
- 2 Total the Man-hours provided on the payroll report.
- 3 Total the Gross Payroll provided.
- 4 Total the Reportable Payroll.

**c. Additional Data Requirements:** If questions are listed in this section of the form, they are unique to this project. Please refer to the Insurance Manual.

**d. Signature Block:** This form must be signed by a representative of your company with the authority to Verify the information is correct.

**Note:** Information can be submitted on-line at [www.aonwrap.aon.com](http://www.aonwrap.aon.com). Please contact your Administration Staff to obtain a user ID and Password.

**A. General Information**

Contractor: 1 \_\_\_\_\_

Under Contract with: 2 \_\_\_\_\_

Contract #: 3 (Project Name) \_\_\_\_\_

Description of Work Performed: 4 \_\_\_\_\_

Date Work Completed: 5 \_\_\_\_\_

Date this Contract Completed: 6 \_\_\_\_\_

**B. Work Completion**

The following Subcontractors have completed their Work at the Project Site(s):

*(Add attachment if more space is needed)*

a Subcontractor's Name	b Contract Number	c Description of Work	d Date Completed
1			

Location of your payroll records *(Receipt of this form will initiate the payroll audit process):*

Address: 2 \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Contact/Phone #: \_\_\_\_\_

**C. Signature Block**

The undersigned acknowledges request for termination of Coverage under the OCIP as of the date indicated above for the specified Contract. Should we return to the work Site(s), we will be working under our own insurance program and must provide BROWARD COUNTY with a Certificate of Insurance showing our own Coverage as detailed in our contract.

**SIGNED BY:** 1 \_\_\_\_\_  
Name & Title Date

**APPROVED BY:** 2 \_\_\_\_\_  
Construction Manager (Name & Title) Date

Fax or Mail to: Roshunda Parker  
Aon Risk Services, Inc. of Florida  
550 NW 10th Street  
Danie, FL 33004

Phone: 954.926.5148  
Fax: 954.926.5149  
Email: roshunda.parker@aon.com

This form will be completed and returned to the OCIP Administrator by the contractor or Subcontractor whenever work is completed for each Contract or Subcontract. This form will initiate the final payroll audit process for the Contractor/Subcontractor identified in item 1. Final Payments and Release of Retainage will not occur until all payroll work is complete and finalized.

**A. General Information**

- 1 Provide the name of the Contractor completing their work.
- 2 Provide the name of the Entity this Contractor has a contract with.
- 3 Enter the contract number for the work being completed.
- 4 Provide a brief description of the work being completed.
- 5 Provide the Date the Work was completed.
- 6 Provide the Date the Contract was completed, if other the work completion date.

**B. Work Completion**

- 1a Enter the name of each Subcontractor that performed work for you that has also completed their work.
- b Enter Subcontractors Contract Number.
- c Provide a brief description of their work.
- d Provide the Date they completed their work.
- 2 Identify the physical location of where your payroll records are retained. Provide the Address, City, State, Zip Code, Contact Name and Telephone Number of the person responsible for maintaining the payroll information for audit purposes.

**C. Signature Block**

- 1 This form must be signed by a representative of your company with the authority to Verify that the information is correct.
- 2 Have this form approved by the Construction Manager for the Project Site(s).

The following contractor has been awarded a contract on the above named project:

Project:	
Contractor Name:	
Contact Name:	
Contractor Address:	_____
City, State, Zip:	
Contractor Federal ID #:	
Contractor Phone Number:	
Contractor Fax Number:	
Contractor E-Mail Address:	

Contract Number:	
Description of Work:	
Contract Amount:	
Estimated Start Date:	
Estimated Completion Date:	
Contractors Required GL Limits::	

Check if Contractor is to be <u>Enrolled</u> in the OCIP:	_____
Check if Contractor is to be <u>Excluded</u> from the OCIP:	_____

**Signature Block**

The undersigned acknowledges request for enrollment / Exclusion of (Sub) Contractor under the OCIP as of the date indicated above for the specified Contract.

<b>SIGNED BY:</b>		
	Name & Title	Date
<b>APPROVED BY:</b>		
	General Contractor (Name & Title)	Date

Fax or Mail to: Roshunda Parker  
Aon Risk Services, Inc. of Florida  
550 NW 10th Street  
Danie, FL 33004

Phone: 954.926.5148  
Fax: 954.926.5149  
Email: Roshunda.parker@aon.com

ACORD®		CERTIFICATE OF INSURANCE			ISSUE DATE: CURRENT DATE	
<b>PRODUCER</b> Insurance Agent's Name And Address  <b>TELEPHONE #</b>		THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW				
<b>INSURED</b>  Subcontractor's Name and Address and <b>contract number</b>  Sample Certificate for <u>Enrolled</u> Contractors  Required Insurance		<b>COMPANIES AFFORDING COVERAGE</b>				
		COMPANY <sup>A</sup>	INSURANCE CARRIER	LETTER		
		COMPANY <sup>B</sup>	INSURANCE CARRIER	LETTER		
		COMPANY <sup>C</sup>	INSURANCE CARRIER	LETTER		
		COMPANY <sup>D</sup>	INSURANCE CARRIER	LETTER		
COVERAGES						
THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN. THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.						
CO LT R	TYPE OF INSURANCE	POLICY NO.	POLICY EFF. DATE MM/DD/YY	POLICY EXP. DATE MM/DD/YY	ALL LIMITS	
A	GENERAL LIABILITY K COMMERCIAL GEN. LIABILITY Y CLAIMS MADE K OCCUR. Y SPONSOR'S & CONTRACTOR'S PROT. K <u>PER PROJECT</u> AGGREGATE ENDORSEMENT	Policy Number			GENERAL AGGREGATE PRODUCTS-COMP/OPS AGGREGATE PERSONAL & ADVERTISING INJURY EACH OCCURRENCE FIRE DAMAGE (Any one fire) MEDICAL EXPENSE (Any one person)	\$2,000,000 \$2,000,000  \$1,000,000 \$ 1,000,000 \$ \$
A	AUTOMOBILE LIABILITY K ANY AUTO Y ALL OWNED AUTOS Y SCHEDULED AUTOS K HIRED AUTOS K NON-OWNED AUTOS	Policy Number			COMBINED SINGLE LIMIT BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE	\$1,000,000
B	EXCESS LIABILITY K UMBRELLA Y OTHER THAN UMBRELLA FORM	Policy Number			EACH OCCURRENCE AGGREGATE	
A	WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY	Policy Number			STATUTORY LIMITS <u>K_FL</u> (Each accident) (Disease-policy limit) (Disease-each employee)	\$1,000,000 \$1,000,000 \$1,000,000
C	OTHER:	Policy Number				
<b>DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS:</b> Broward County Board of Commissioners, its commissioners, officers, directors, agents, employees, related entities, authorized representatives, servants, and assigns are Additional Insureds on a Primary and Non-Contributory basis for General Liability, Automobile Liability and Excess/Umbrella coverage. Waiver of Subrogation in favor of Certificate Holder and all Contractors and Subcontractors applies to all policies. General Liability and Worker's Compensation apply Off-Site(s).						
<b>CERTIFICATE HOLDER</b>  Broward County c/o Aon Risk Services, Inc. 550 NW 10 <sup>th</sup> Street Dania, Florida 33004 Attention: Roshunda Parker Fax: 954.926.5149 Email: Roshunda.Parker@aon.com			<b>CANCELLATION</b> SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL <b>30</b> DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, <b>BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.</b>			
			<b>AUTHORIZED REPRESENTATIVE</b> By: <i>original signature</i>			
ACORD 25-S (3/93)			© ACORD CORPORATION 1993			



FIRST REPORT OF INJURY OR ILLNESS  
**FLORIDA DEPARTMENT OF FINANCIAL SERVICES**  
**DIVISION OF WORKERS' COMPENSATION**

For assistance call 1-800-342-1741 or contact your local EAO Office. Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

PLEASE PRINT OR TYPE

RECEIVED BY CARRIER	SENT TO DIVISION	DIVISION REC'D DATE

**EMPLOYEE INFORMATION**

Name (First, Middle, Last)		Social Security	Date of Accident	Time of
Home Address		Employee's Description of Accident (Include Cause of injury)		
Street/Apt #:				
City:		State:		
Zip:		Telephone:		
OCCUPATION		Cause of Injury:		
DATE OF BIRTH	SEX	INJURY/ILLNESS THAT OCCURED	PART OF BODY AFFECTED	

**EMPLOYER INFORMATION**

Company D.B.A.: Contact:	FEDERAL ID NUMBER (FEIN)	DATE FIRST REPORTED		
Street: City: State : <b>FL</b> Zip:	NATURE OF BUSINESS	POLICY/MEMBER NUMBER		
Telephone Number:	DATE EMPLOYED	PAID FOR DATE OF INJURY		
Employer's Location Address (if different)	LAST DATE EMPLOYEE WORKED	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP?		
Street:	RETURNED TO WORK	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP		
City:	IF YES, GIVE DATE	RATE OF PAY PER		
State: <b>FL</b> Zip: Location # :		Hour	Week	
		Day	Month	
Place of Accident (street, city, Zip)	DATE OF DEATH (if applicable)	Number of hours per day		
Street:	AGREE WITH DESCRIPTION OF ACCIDENT	Number of hours per week		
City:		Number of days per week		
State: Zip:				
County of Accident:	NAME, ADDRESS AND TELEPHONE OF <del>OF PHYSICIAN OR HOSPITAL</del>			
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234, Section 440.105(7), F.S. <b>I have reviewed, understand and acknowledge the above statement.</b>	<b>Physician:</b>			
	<b>Hospital:</b>			
	AUTHORIZED BY EMPLOYER			
Employee Signature	Date		Yes	
Employee Signature	Date			

**CLAIMS-HANDLING ENTITY INFORMATION**

<input type="checkbox"/> 1(a) Denied Case - DWC-12, Notice of Denial Attached	<input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3)
<input type="checkbox"/> 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached	Employee's 8TH Day of Disability _____ / _____ / _____
	Entity's Knowledge of 8TH Day of Disability _____ / _____ / _____
<input type="checkbox"/> 3. Lost Time Case - 1st day of disability ____ / ____ / ____	Full Salary in lieu of comp? <input type="checkbox"/> YES Full Salary End Date ____ / ____ / ____
Date First Payment Mailed _____ / _____ / _____	AWW _____ Comp Rate _____
<input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY	
Penalty Amount Paid in 1st Payment \$ _____	Interest Amount Paid in 1st Payment \$ _____
REMARKS:	INSURER NAME
INSURER Code	EMPLOYEE'S RISK CLASS CODE
	EMPLOYER'S NAICS CODE
Service Co/TPA Code #	CLAIMS-HANDLING ENTITY FILE #
	<b>Old Republic General</b>

**Broward County Board of County Commissioners  
Risk Management Division  
Loss Notice**

1. TYPE OF INCIDENT:  Vehicle  Injury  Public Disturbance  Patron Property Damage  County Property/Loss  
(Select all that apply)  Other /Specify

Date of Incident: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm Division: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Exact Location: \_\_\_\_\_

Description of Incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Photographs Taken:  Yes (Attach)  No Area Inspected: \_\_\_\_\_ Weather Conditions: \_\_\_\_\_

Name of Police Dept./Authorities Notified: \_\_\_\_\_ Report/Case No.# \_\_\_\_\_

Tickets Issued?  Yes  No To Whom? \_\_\_\_\_ Charges? \_\_\_\_\_

Employee Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Employees on Duty: (Attach List) \_\_\_\_\_

**2. COUNTY VEHICLE ACCIDENT:**

County Driver: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Vehicle Unit #: \_\_\_\_\_ Year \_\_\_\_\_ Model: \_\_\_\_\_ Tag#: \_\_\_\_\_ Location of Vehicle: \_\_\_\_\_

Area of Damage: \_\_\_\_\_ Estimated Damages: \_\_\_\_\_ Seat Belts Used:  Yes  No

Passengers: Please complete Section 4. Witnesses

Other Vehicle: (If more than one, use additional sheets)

Owner: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Home & Cell Phone: \_\_\_\_\_

Other Driver: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Home & Cell Phone: \_\_\_\_\_

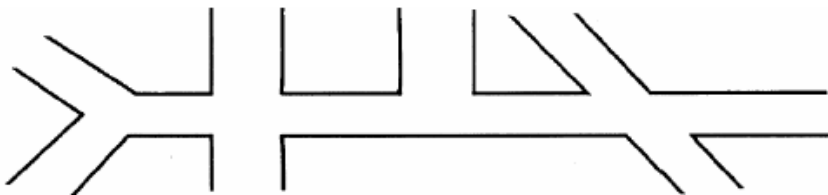
Insurance Company: \_\_\_\_\_ Policy No: \_\_\_\_\_

Vehicle Year \_\_\_\_\_ Model: \_\_\_\_\_ Tag # \_\_\_\_\_ Location of Vehicle: \_\_\_\_\_

Area of Damage: \_\_\_\_\_ Estimated Damages: \_\_\_\_\_ Seat Belts Used:  Yes  No

Passengers: Please complete section 4. Witnesses

**3. DIAGRAM:** County vehicle or employee's vehicle driven on County business must be "vehicle 1".



**4. WITNESSES:** (If more than three use additional sheets) (If witness is a vehicle passenger please indicate which vehicle number they were a passenger in.)

Name & Address: \_\_\_\_\_

Home & Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name & Address: \_\_\_\_\_

Home & Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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**5. PROPERTY DAMAGE TO OTHERS:**

Name/Owner: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Describe Damages: \_\_\_\_\_

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**6. INJURED PERSONS:** (If more than two, use additional sheets)

A. Name & Address: \_\_\_\_\_

Home & Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ D/O/B or Age: \_\_\_\_\_

Describe injuries: \_\_\_\_\_

Name of Doctor & Address: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ Transported:  Yes  No Seat Belt in Use:  Yes  No

B. Name & Address: \_\_\_\_\_

Home & Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ D/O/B or Age: \_\_\_\_\_

Describe injuries: \_\_\_\_\_

Name of Doctor & Address: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ Transported:  Yes  No Seat Belt in Use:  Yes  No

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**7. COUNTY PROPERTY DAMAGE:**

Fire  Theft  Vandalism  Cash Shortage/Overage Other/Specify \_\_\_\_\_

Describe Damages: \_\_\_\_\_

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Asset #: \_\_\_\_\_ Model #: \_\_\_\_\_

Cost to Repair/Replace: \_\_\_\_\_ Attach Estimate/Invoice Police or Fire Dept. \_\_\_\_\_ Attach Report

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**8. OTHER PARTY INVOLVED:**

Company Name & Address \_\_\_\_\_

Contact Name & Phone Number: \_\_\_\_\_

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**9. ACTION TAKEN TO PREVENT REOCCURRENCE:** \_\_\_\_\_

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Report completed by: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Supervisor/Director: \_\_\_\_\_