



WORKERS' COMPENSATION INSURANCE PLAN
P.O. Box 40767 TOLL FREE: 866-221-9640
Lansing, MI 48901-7967 FAX: 844-778-1070
NCCI Carrier Code: 19968 EMAIL: Policy@AssignedRiskSolutions.com
AssignedRiskSolutions.com

**Workers' Compensation
and Employers Liability
Insurance Policy**

Date of Mailing: 05/14/2020

U SEAL USA LLC
125 OLD IRON ORE RD
BLOOMFIELD, CT 06002-1424

Dear Policyholder:

Welcome to the Workers' Compensation Insurance Plan (WCIP). Your policy, ARP12002482201, effective 05/30/2020, will be underwritten by Accident Fund Insurance Company of America and serviced by Assigned Risk Solutions, a division of AF Group, who will work diligently to ensure your satisfaction throughout the lifetime of your WCIP policy.

- A wide array of services are available online at the website address provided below. If you wish to speak with someone to discuss your policy or request any of these services, contact us at 866-221-9640 during business hours (8 a.m. to 5 p.m. EST). Should you or your employees need to report a workers' compensation claim, contact our Claims team:

- Online: AssignedRiskSolutions.com
- Fax a first report of injury: 844-778-1069
- Call: 866-221-9640

- To accelerate the claims process, contact us as soon as possible – preferably within 24 hours of the reported injury.

- We provide your business access to helpful online information, including loss control materials, pharmacy management, return-to-work and pre-injury program information. You can obtain these resources online or by phone. You can also sign up to receive monthly e-blasts on a variety of workplace safety topics. Visit AssignedRiskSolutions.com to learn more.

Need more info?

The following information concerning your policy can be found at AssignedRiskSolutions.com:

- Claims reporting and claim review
- Find a medical provider
- Sign up to receive policy documents electronically
- Issue certificates of insurance
- Obtain loss history
- Online bill pay
- Complete online self audits
- Free access to online safety e-blasts, loss control tips, return-to-work literature, and more

Our customers are the most important part of our business and we work diligently to ensure your complete satisfaction throughout the lifetime of your policy. We appreciate your business.

Sincerely,

Assigned Risk Solutions

Accident Fund Insurance Company of America is a member of AF Group. All policies are underwritten by a licensed insurer subsidiary of AF Group.



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**Workers' Compensation
and Employers Liability
Insurance Policy**

Date of Mailing: 05/14/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

MANAGING EXPOSURE CONNECTICUT CONSTRUCTION INDUSTRY AND THE USE OF SUBCONTRACTORS
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

If you are a construction contractor in Connecticut, any hiring of subcontractors (and their employees) opens up your risk for liability for work-related injuries. In fact, Connecticut workers' compensation law designates the primary contractor as liable for workplace injuries of employees of uninsured subcontractors as well as for any uninsured subcontractor who fails to meet the minimum requirements needed to establish independent contractor status. [Workers Compensation Act Sec. 31-291.]

To Avoid Providing Coverage for Subcontractors:

You must obtain valid, current workers' compensation certificates of insurance for any dates a subcontractor or independent contractor works for you.

Valid certificates of insurance give us the ability to defend against claims brought against your policy with us by these workers. Every certificate you receive for anyone doing work for you should be sent to us within a reasonable time period (two weeks). If a certificate expires but the subcontractor is still working for you, it is your responsibility to obtain an updated certificate and provide that to us. Remember that it is always easier to obtain documentation when you are actively working with the person, rather than after the job is finished. You can, and should, require a current workers' compensation certificate prior to letting anyone on your jobsite to avoid liability and consequently paying premium.

If Your Subcontractors Are Not Insured/Exempt:

By law, your policy with us is insuring them and their employees, since you are the primary contractor. This means premium will be charged on your policy for each worker. If your subcontractor is not insured and they have employees, you are also liable for their employees' coverage and premium will be charged accordingly.

If certificates are unavailable for any workers hired, you must provide us with description(s) of the work being performed and estimate annual payroll for each job. By doing this, we can accurately estimate the premium and allow a payment plan based on your premium size as approved by the Plan. If payroll estimates change, you must provide us with updated estimates as soon as you are able.

The End Result:

At the end of every policy term, we will perform a payroll audit to determine final exposure and premium. This will be based on actual exposure, rather than estimates, and all certificates as well as all payroll records will be required at this time to ensure the most accurate premium is calculated. Please contact our office with any questions you may have regarding the use of subcontractors or independent contractors, certificates of workers' compensation, and/or final audits. Our contact information is listed above.

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

GENERAL SECTION

A. The Policy

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

B. Who is Insured

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

C. Workers Compensation Law

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

D. State

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

E. Locations

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

PART ONE

WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

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

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

B. We Will Pay

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

C. We Will Defend

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

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

D. We Will Also Pay

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

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

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other



(Ed. 1-15)

insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. Payments You Must Make

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

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

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

G. Recovery From Others

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

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you and us.
4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the

workers compensation law that apply to:

- a. benefits payable by this insurance;
- b. special taxes, payments into security or other special funds, and assessments payable by us under that law.

6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

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

**PART TWO
EMPLOYERS LIABILITY INSURANCE****A. How This Insurance Applies**

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

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

B. We Will Pay

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

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

1. For which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against



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such third party as a result of injury to your employee;

2. For care and loss of services; and
3. For consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee; provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and
4. Because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. Exclusions

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. Bodily injury intentionally caused or aggravated by you; Bodily injury occurring outside the United States of
6. America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901 et seq.), the Non-appropriated Fund Instrumentalities Act (5 USC Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 USC Sections 1331 et seq.), the Defense Base Act (42 USC Sections 1651-1654), the Federal Mine Safety and Health Act (30 USC Sections 801 et seq. and 901-944), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;

9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51 et seq.), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. Bodily injury to a master or member of the crew of any vessel, and does not cover punitive damages related to your duty or obligation to provide transportation, wages, maintenance, and cure under any applicable maritime law;
11. Fines or penalties imposed for violation of federal or state law; and
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued there under, and any amendments to those laws.

D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits. We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. We Will Also Pay

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

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



(Ed. 1-15)

F. Other Insurance

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

G. Limits of Liability

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

1. **Bodily Injury by Accident.** The limit shown for "bodily injury by accident—each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.
A disease is not bodily injury by accident unless it results directly from bodily injury by accident.
2. **Bodily Injury by Disease.** The limit shown for "bodily injury by disease—policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease—each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee. Bodily injury by disease does not include disease that results directly from a bodily injury by accident.
3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

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

I. Actions Against Us

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

1. You have complied with all the terms of this policy; and

2. The amount you owe has been determined with our consent or by actual trial and final judgment.
This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

**PART THREE
OTHER STATES INSURANCE****A. How This Insurance Applies**

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

B. Notice

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

**PART FOUR
YOUR DUTIES IF INJURY OCCURS**

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

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal



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papers related to the injury, claim, proceeding or suit.

4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE—PREMIUM

A. Our Manuals

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

B. Classifications

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

C. Remuneration

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

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

D. Premium Payments

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

E. Final Premium

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

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

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

F. Records

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

G. Audit

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



PART SIX—CONDITIONS**A. Inspection**

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

B. Long Term Policy

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

C. Transfer of Your Rights and Duties

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

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

D. Cancellation

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

E. Sole Representative

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

In Witness Whereof, Accident Fund Insurance Company of America, a Stock Company, has caused this policy to be issued and signed by its President and Corporate Secretary at Lansing, Michigan.

Al Gileczek, President



Bobbi J. Elliott, Corporate Secretary



**WORKERS' COMPENSATION INSURANCE PLAN**

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**Workers' Compensation
and Employers Liability
Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Legal Entity: Limited liability company

Policy Number

ARP12002482201

INFORMATION PAGE**WCIP**

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

Other Workplaces Not Shown Above: See schedule attached**ITEM 2. POLICY PERIOD** is from 12:01 A.M. 05/30/2020 to 12:01 A.M. 05/30/2021 Standard Time at the insured's mailing address.**ITEM 3. COVERAGE**

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

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

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

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

WC000326A

D. This policy includes these endorsements and schedules:

WC 00 00 00 C	WC 00 00 01 A	WC 00 01 15	WC 00 03 08	WC 00 03 26 A	WC 00 04 03	WC 00 04 04	WC 00 04 06
WC 00 04 14 A	WC 00 04 15 B	WC 00 04 17 B	WC 00 04 19	WC 00 04 21 D	WC 00 04 22 B	WC 00 04 24	WC 06 03 01 C
WC 06 03 03 C	WC 06 06 01 A	WC 06 06 02	WC 99 00 01 A	WC 99 06 01 B			

ITEM 4. PREMIUM

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

CLASSIFICATIONS**SEE SCHEDULE OF CLASSIFICATIONS ON FOLLOWING PAGE(S)**

Minimum Premium	Deposit Premium	Experience Modification	Total Estimated Annual Premium	Premium Adjustment Period:
\$ 1,500.00	\$ 1,685.00	N/A	\$ 1,620.00	Annually
		Expense Constant: \$ 160.00		
		Total Policy Fees: \$ 65.00		
		Total Policy Cost: \$ 1,685.00		

Signature:





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**Workers' Compensation
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Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020	05/30/2021
	12:01 A.M. Standard Time at the described location	

PAYMENT SCHEDULE

WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319

Intrastate ID:

Tax ID #: 27-4348330

Bureau Risk ID:

State ID #:

THIS IS NOT A BILL **

Policy Term Payment Schedule*

Due Date	Invoice Amount
06/13/2020	\$ 1,685.00

Total Amount Paid To Date (this amount may not reflect recent payments): \$ 1,685.00

*The Payment Schedule above does not reflect the amount paid to date.

**This is not a bill - you will be invoiced separately 30 days prior to each due date.

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Form_PaySch_01, 01/2017





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**Workers' Compensation
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CLASSIFICATION SCHEDULE
WCIP

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U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

CLASS CODE NO. AND CLASSIFICATION	ESTIMATED RENUMERATION	RATE PER \$100	ESTIMATED ANNUAL PREMIUM
STATE: CT Rating Period: 05/30/2020 - 05/30/2021			
Entity Name: U SEAL USA LLC			
Effective Date Entity Location: 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424			
05/30/2020 5221 CONCRETE OR CEMENT WORK-FLOORS, DRIVEWAYS, YARDS OR SIDEWALKS-& DRIVERS	.00	9.71	0.00
05/30/2020 5506 STREET OR ROAD CONSTRUCTION: PAVING OR REPAVING & DRIVERS	.00	12.28	0.00
Total Manual Premium			\$ 0.00
Increased Limit Charge			\$ 120.00
Minimum Premium Adjustment			\$ 1,340.00
Total Standard Premium			\$ 1,460.00
Expense constant			\$ 160.00
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement		0.03	\$ 0.00
Catastrophe (Other Than Certified Acts of Terrorism)		0.01	\$ 0.00
Total Audited Annual Premium			\$ 1,620.00
Second Injury Fund Surcharge		0.0173	\$ 25.00
WC Administration Fund - Non Federal		0.023	\$ 35.00
WC Administration Fund - Federal		0.041	\$ 5.00
Total Fees and Surcharges			\$ 65.00
Total Audited Annual Premium and Fees			\$ 1,685.00





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**Workers' Compensation
and Employers Liability
Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

CLASSIFICATION SCHEDULE

WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

Policy Summary

Total Manual Premium	\$ 0.00
Increased Limit Charge	\$ 120.00
Minimum Premium Adjustment	\$ 1,340.00
Total Standard Premium	\$ 1,460.00
Expense constant	\$ 160.00
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	\$ 0.00
Catastrophe (Other Than Certified Acts of Terrorism)	\$ 0.00
Total Estimated Annual Premium	\$ 1,620.00
Second Injury Fund Surcharge	\$ 25.00
WC Administration Fund - Non Federal	\$ 35.00
WC Administration Fund - Federal	\$ 5.00
Total Fees and Surcharges	\$ 65.00
Total Estimated Annual Premium and Fees	\$ 1,685.00





WORKERS' COMPENSATION INSURANCE PLAN
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NCCI Carrier Code: 19968 EMAIL: Policy@AssignedRiskSolutions.com
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**Workers' Compensation
and Employers Liability
Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

ENTITY AND LOCATION SCHEDULE

WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

Schedule of Named Entities

Number	Name	FEIN	Entity Type
1	U SEAL USA LLC	27-4348330	Limited liability company

SCHEDULE OF COVERED WORKPLACES

Number	Address
1	125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424

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**Workers' Compensation
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Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

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	12:01 A.M. Standard Time at the described location	

**NOTIFICATION ENDORSEMENT OF PENDING LAW CHANGE TO
TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT OF 2015**
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

This endorsement is being attached to your workers compensation and employers liability insurance policy. This endorsement does not replace the separate Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 B) that is attached to your current policy and which remains in effect as applicable.

The Terrorism Risk Insurance Act of 2002 (TRIA), as previously amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2015 (TRIPRA 2015), provides for a program under which the federal government will share in the payment of insured losses caused by certain acts of terrorism. In the absence of affirmative US Congressional action to extend, update, or otherwise reauthorize TRIPRA 2015, in whole or in part, TRIPRA 2015 is scheduled to expire on December 31, 2020.

Since the timetable for any further Congressional action regarding TRIPRA 2015 is presently unknown, and exposure to acts of terrorism remains, we are providing policyholders with relevant information concerning their workers compensation policies in the event of the TRIPRA 2015's expiration.

Your policy provides coverage for workers compensation losses caused by acts of terrorism, including workers compensation benefit obligations dictated by state law, except in Pennsylvania, where injuries or deaths resulting from certain war-related activities are excluded from workers compensation coverage. Coverage for such losses is still subject to all terms, definitions, exclusions, and conditions in your policy.

The premium charge for the coverage that your policy provides for terrorism losses is shown in Item 4 of the policy Information Page or the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 B) Schedule that is attached to your policy. This amount may continue or change for new, renewal, and in-force policies in effect on or after December 31, 2020, in the event of TRIPRA 2015's expiration, subject to regulatory review in accordance with applicable state law.

You need not do anything further at this time.

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**Workers' Compensation
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ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

PARTNERS, OFFICERS, AND OTHERS EXCLUSION ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
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Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

The policy does not cover bodily injury to any person described in the Schedule.

The premium basis for the policy does not include the remuneration of such persons.

You will reimburse us for any payment we must make because of bodily injury to such persons.

	Schedule	
Partners	Officers	Others
		JOSEPH MURPHY





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**Workers' Compensation
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Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

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RESIDUAL MARKET LIMITED OTHER STATES INSURANCE ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
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Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

"Part Three—Other States Insurance" of the policy is replaced by the following:

PART THREE OTHER STATES INSURANCE

A. How This Insurance Applies

1. We will pay promptly when due the benefits required of you by the workers compensation law of any state not listed in Item 3.A. of the Information Page if all of the following conditions are met:
 - a. The employee claiming benefits was either hired under a contract of employment made in a state listed in Item 3.A. of the Information Page; and
 - b. The employee claiming benefits is not claiming benefits in a state where, at the time of injury, (i) you have other workers compensation insurance coverage, or (ii) you were, by virtue of the nature of your operations in that state, required by that state's law to have obtained separate workers compensation insurance coverage, or (iii) you are an authorized self-insurer or participant in a self-insured group plan; and
 - c. The duration of the work being performed by the employee claiming benefits in the state for which that employee is claiming benefits is temporary.
2. If we are not permitted to pay the benefits directly to persons entitled to them and all of the above conditions are met, we will reimburse you for the benefits required to be paid.
3. This insurance does not apply to fines or penalties arising out of your failure to comply with the requirements of the worker's compensation law.

IMPORTANT NOTICE I

If you hire any employees outside those states listed in Item 3.A. on the Information Page or begin operations in any such state, you should do whatever may be required under that state's law, as this endorsement does not satisfy the requirements of that state's workers compensation law.





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**Workers' Compensation
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Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

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ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

WCIP

ITEM 1 - Named Insured and Address	Agency
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Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

The premium for the policy will be adjusted by an experience rating modification factor. The factor was not available when the policy was issued. The factor, if any, shown on the Information Page is an estimate. We will issue an endorsement to show the proper factor, if different from the factor shown, when it is calculated.





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Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

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PENDING RATE CHANGE ENDORSEMENT

WCIP

ITEM 1 - Named Insured and Address	Agency
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Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

A rate change filing is being considered by the proper regulatory authority. The filing may result in rates different from the rates shown on the policy. If it does, we will issue an endorsement to show the new rates and their effective date.

If only one state is shown in Item 3.A. of the Information Page, this endorsement applies to that state. If more than one state is shown there, this endorsement applies only in the state shown in the Schedule.

Schedule

State
CT





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**Workers' Compensation
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Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

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PREMIUM DISCOUNT ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
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Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

The premium for this policy and the policies, if any, listed in Item 3 of the Schedule may be eligible for a discount. This endorsement shows your estimated discount in Items 1 or 2 of the Schedule. The final calculation of premium discount will be determined by our manuals and your premium basis as determined by audit. Premium subject to retrospective rating is not subject to premium discount.

Schedule

1. State	Estimated Eligible Premium			
	First	Next	Next	Balance
	\$5,000	\$95,000	\$400,000	
2. Average percentage discount: %				
3. Other policies:				
4. If there are no entries in Items 1, 2 and 3 of the Schedule, see the Premium Discount Endorsement attached to your policy number:				





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Renewal of Policy: ARP12002482200

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90-DAY REPORTING REQUIREMENT - NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

You must report any change in ownership to us in writing within 90 days of the date of the change. Change in ownership includes sales, purchases, other transfers, mergers, consolidations, dissolutions, formations of a new entity, and other changes provided for in the applicable experience rating plan. Experience rating is mandatory for all eligible insureds. The experience rating modification factor, if any, applicable to this policy, may change if there is a change in your ownership or in that of one or more of the entities eligible to be combined with you for experience rating purposes.

Failure to report any change in ownership, regardless of whether the change is reported within 90 days of such change, may result in revision of the experience rating modification factor used to determine your premium.

This reporting requirement applies regardless of whether an experience rating modification is currently applicable to this policy.





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**Workers' Compensation
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Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

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Policy Number	Policy Period	
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ARP12002482201	05/30/2020	05/30/2021
12:01 A.M. Standard Time at the described location		

ASSIGNED RISK ADJUSTMENT PROGRAM ENDORSEMENT

WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

This endorsement is attached to your policy and incorporates the following additional provisions into Part Five (Premium) of your policy because one or more of the states shown in Item 3.A. of the Information Page have approved the Assigned Risk Adjustment Program (ARAP). ARAP adds a surcharge to the premium of assigned risk employers who meet the criteria of ARAP.

The application of ARAP is mandatory and shall apply to all assigned risk policies written in approved jurisdictions who meet the criteria of ARAP.

If your experience rating modification changes, the ARAP surcharge factor may also change.

A. Criteria

1. You will receive an ARAP surcharge factor calculated by the designated rating/advisory organization for your intrastate and/or interstate risk if you:
 - a. Are experience rated, and
 - b. Have an experience rating modification that includes data from at least one ARAP-approved jurisdiction, and
 - c. Have a calculated experience rating modification factor greater than or equal to 1.01, and
 - d. Meet or exceed the weighted test ratio in accordance with the applicable rules in NCCI's *Basic Manual for Workers Compensation and Employers Liability Insurance* or other applicable state rules.
2. You will not receive an ARAP surcharge factor calculated by the designated rating/advisory organization in an ARAP approved jurisdiction if you:
 - a. Are not experience rated, or
 - b. Are an intrastate and/or interstate experience rated risk that does not have any ARAP-approved jurisdictions data included in your experience rating modification calculation, or
 - c. Have a calculated experience rating modification equal to or less than 1.00.

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WC 00 04 15 B, 1/1/2010





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ASSIGNED RISK ADJUSTMENT PROGRAM ENDORSEMENT

WCIP

ITEM 1 - Named Insured and Address	Agency
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Bureau Risk ID:	State ID #:

B. Surcharge Application

You must pay a surcharge based on a comparison of your actual and expected losses, as determined using values from your experience rating modification calculation. The ARAP surcharge factor is applied by multiplying your assigned risk total modified premium by the ARAP surcharge factor. The total modified premium of an assigned risk policy in ARAP-approved jurisdictions is determined in accordance with the applicable state assigned risk premium algorithm, or any other applicable programs or statutory requirements. The ARAP surcharge factor is included in total standard premium.

C. Multistate Operations

If you are an experience rated employer with multistate operations, you shall be subject to the Assigned Risk Adjustment Program in states that have approved ARAP, and as applied by your insurance carrier in those states as shown in the Schedule below.

D. Cancellation

If your policy is cancelled, the ARAP surcharge factor is applied in accordance with Part Five (Premium), E. of your workers compensation and employers liability insurance policy.

Schedule

State
CT





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ASSIGNED RISK LOSS SENSITIVE RATING PLAN NOTIFICATION ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

A. LSRP Mandatory Assigned Risk Retrospective Rating Plan

This endorsement is to advise you that, during the term of this policy or upon renewal, you may become subject to the mandatory assigned risk Loss Sensitive Rating Plan (LSRP), which is a retrospective rating plan that may adjust the cost of your workers compensation and employers liability insurance policy. This endorsement must be attached to all assigned risk policies, including policies for professional employer organization (PEO) and temporary arrangements, regardless of LSRP standard premium size in states that have approved the LSRP. In the event that you meet or exceed the eligibility requirements of LSRP, an LSRP contingent deposit equal to 20% of LSRP standard premium is required.

B. Eligibility

1. Your insurance is written under a Workers Compensation Insurance Plan (WCIP) in a state that has approved LSRP.

2.

- LSRP will apply to an individual assigned risk policy if the standard premium meets or exceeds the amount noted in the Schedule, in accordance with NCCI's *Basic Manual*.
- It may not always be possible for a single carrier to provide coverage for all requested states; additional policies issued by more than one carrier may be necessary.
- WCIP policies issued in non-LSRP-approved jurisdictions are not subject to LSRP and are not combinable with WCIP policies in LSRP-approved jurisdictions for eligibility purposes.
- LSRP eligibility may be impacted by ownership or combinability status in accordance with NCCI's *Experience Rating Plan Manual*.

3. LSRP standard premium is defined in accordance with NCCI's *Basic Manual*.



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**Workers' Compensation
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Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

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ASSIGNED RISK LOSS SENSITIVE RATING PLAN NOTIFICATION ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

C. Deposit/Initial Premium and LSRP Contingency Deposit

1. Deposit or initial premium is paid on all new and renewal WCIP policies, including LSRP policies, in accordance with NCCI's *Basic Manual*. It is paid to us in addition to the LSRP contingency deposit, which secures all new and renewal LSRP policies as detailed in the LSRP rules.
2. The LSRP contingency deposit paid to us serves as collateral for premium that may be due to us as a result of losses incurred during the policy term.
3. At policy inception, the LSRP contingency deposit is calculated by multiplying the LSRP standard premium by 20%. If WCIP policies are combined for LSRP purposes, the LSRP contingency deposit is calculated by multiplying the combined LSRP standard premium for all policies by 20%.

D. Impact of Changes in LSRP Standard Premium

1. For all policies except for professional employer organizations (PEOs) and temporary arrangements, LSRP may be applied to a policy, or an LSRP policy may be converted to a guaranteed cost policy:
 - a. If the LSRP standard premium decreases during the first 120 days, and falls below the LSRP eligibility threshold, your policy will be converted to a guaranteed cost policy, retroactive to policy inception, and your LSRP contingency deposit will be returned.
 - b. If the LSRP standard premium increases during the first 120 days, and meets the LSRP eligibility threshold, LSRP will be applied retroactively to policy inception and the 20% LSRP contingency deposit must be paid to us within 30 days of us issuing notice to you of the application of LSRP.
 - c. If the LSRP standard premium decreases after the first 120 days and falls below the LSRP eligibility threshold, the LSRP continues to be applied to your policy(ies).
 - d. If the LSRP standard premium increases after the first 120 days, and meets the LSRP eligibility threshold, your policy(ies) will remain a guaranteed cost policy(ies) and the LSRP is applied at renewal, subject to meeting the eligibility requirements or the renewal policy(ies).
2. For all PEO and temporary arrangement WCIP policies, if the LSRP standard premium meets or exceeds the eligibility threshold **any time**, LSRP is applied retroactively to policy inception. The 20% LSRP contingency deposit must be paid to us within 30 days of us issuing notice to you of the application of LSRP.





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ASSIGNED RISK LOSS SENSITIVE RATING PLAN NOTIFICATION ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
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Bureau Risk ID:	State ID #:

E. Evasion of LSRP

1. If you take actions for the purpose of avoiding the application of LSRP, or for otherwise legitimate business reasons that nonetheless result in the improper calculation and/or application of LSRP, regardless of intent, any action that results in the miscalculation and/or misapplication of LSRP determined in accordance with the LSRP rules is prohibited. These actions include, but are not limited to:
Misrepresentation and/or miscalculation of payroll at application, audit, or renewal
 - Failure to report changes in ownership or ownership information according to the WCIP and NCCI's *Experience Rating Plan Manual*
 - Violation of any of the terms and conditions under the policy for which this insurance was issued
 - Failure to allow us and/or the Plan Administrator and/or rating organization reasonable access to your facilities or files and records for audit or inspection
 - Failure to disclose to us and/or the Plan Administrator and/or rating organization the full nature and scope of your exposure or business operations
2. In such circumstances, we and/or the Plan Administrator and/or rating organization may obtain any information that indicates evasion or improper calculation or application of LSRP due to actions including, but not limited to, those listed above. We and/or the Plan Administrator and/or rating organization will act to ensure the proper calculation and application of LSRP to inception of all current and preceding WCIP policies impacted by these actions.
This endorsement applies in the states listed in the Schedule below.

State	Schedule	Premium Eligibility
CT		\$250,000





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PREMIUM DUE DATE ENDORSEMENT

WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

This endorsement is used to amend:

Section D. of Part Five of the policy is replaced by this provision.

**PART FIVE
PREMIUM**

- D. **Premium** is amended to read:
You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid. **The due date for audit and retrospective premiums is the date of the billing.**





WORKERS' COMPENSATION INSURANCE PLAN
P.O. Box 40767 TOLL FREE: 866-221-9640
Lansing, MI 48901-7967 FAX: 844-778-1070
NCCI Carrier Code: 19968 EMAIL: Policy@AssignedRiskSolutions.com
AssignedRiskSolutions.com

**Workers' Compensation
and Employers Liability
Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

This endorsement is notification that your insurance carrier is charging premium to cover the losses that may occur in the event of a Catastrophe (other than Certified Acts of Terrorism) as that term is defined below. Your policy provides coverage for workers compensation losses caused by a Catastrophe (other than Certified Acts of Terrorism). This premium charge does not provide funding for Certified Acts of Terrorism contemplated under the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 B), attached to this policy.

For purposes of this endorsement, the following definitions apply:

- Catastrophe (other than Certified Acts of Terrorism): Any single event, resulting from an Earthquake, Noncertified Act of Terrorism, or Catastrophic Industrial Accident, which results in aggregate workers compensation losses in excess of \$50 million.
- Earthquake: The shaking and vibration at the surface of the earth resulting from underground movement along a fault plane or from volcanic activity.
- Noncertified Act of Terrorism: An event that is not certified as an Act of Terrorism by the Secretary of Treasury pursuant to the Terrorism Risk Insurance Act of 2002 (as amended) but that meets all of the following criteria:
 - a. It is an act that is violent or dangerous to human life, property, or infrastructure;
 - b. The act results in damage within the United States, or outside of the United States in the case of the premises of United States missions or air carriers or vessels as those terms are defined in the Terrorism Risk Insurance Act of 2002 (as amended); and
 - c. It is an act that has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.





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**Workers' Compensation
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Renewal of Policy: ARP12002482200

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ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

- Catastrophic Industrial Accident: A chemical release, large explosion, or small blast that is localized in nature and affects workers in a small perimeter the size of a building.

The premium charge for the coverage your policy provides for workers compensation losses caused by a Catastrophe (other than Certified Acts of Terrorism) is shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
CT	0.01	Rate per \$100 of Remuneration





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**Workers' Compensation
and Employers Liability
Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2015. It serves to notify you of certain limitations under the Act, and that your insurance carrier is charging premium for losses that may occur in the event of an Act of Terrorism.

Your policy provides coverage for workers compensation losses caused by Acts of Terrorism, including workers compensation benefit obligations dictated by state law. Coverage for such losses is still subject to all terms, definitions, exclusions, and conditions in your policy, and any applicable federal and/or state laws, rules, or regulations.

Definitions

The definitions provided in this endorsement are based on and have the same meaning as the definitions in the Act. If words or phrases not defined in this endorsement are defined in the Act, the definitions in the Act will apply.

"Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments thereto, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.

"Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States as meeting all of the following requirements:

- The act is an act of terrorism.
- The act is violent or dangerous to human life, property or infrastructure.
- The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.
- The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.





WORKERS' COMPENSATION INSURANCE PLAN
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**Workers' Compensation
and Employers Liability
Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020	05/30/2021
12:01 A.M. Standard Time at the described location		

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319

Intrastate ID:

Tax ID #: 27-4348330

Bureau Risk ID:

State ID #:

"Insured Loss" means any loss resulting from an act of terrorism (and, except for Pennsylvania, including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.

"Insurer Deductible" means, for the period beginning on January 1, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums, during the immediately preceding calendar year.

Limitation of Liability

The Act limits our liability to you under this policy. If aggregate Insured Losses exceed \$100,000,000,000 in a calendar year and if we have met our Insurer Deductible, we are not liable for the payment of any portion of the amount of Insured Losses that exceeds \$100,000,000,000; and for aggregate Insured Losses up to \$100,000,000,000, we will pay only a pro rata share of such Insured Losses as determined by the Secretary of the Treasury.

Policyholder Disclosure Notice

- Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
 - \$100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
 - \$120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.
 - \$140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.
 - \$160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.

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WC 00 04 22 B , 1/1/2015



**WORKERS' COMPENSATION INSURANCE PLAN**

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**Workers' Compensation
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Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

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TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

- e. \$180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.
- f. \$200,000,000, with respect to such Insured Losses occurring in calendar year 2020, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed \$100,000,000,000.
3. The premium charge for the coverage your policy provides for Insured Losses is included in the amount shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
CT	0.03	Rate per \$100 of Remuneration





WORKERS' COMPENSATION INSURANCE PLAN
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**Workers' Compensation
and Employers Liability
Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020	05/30/2021
	12:01 A.M. Standard Time at the described location	

AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

Part Five-Premium, Section G. (Audit) of the Workers Compensation and Employers Liability Insurance Policy is revised by adding the following:

If you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we may apply an Audit Noncompliance Charge. The method for determining the Audit Noncompliance Charge by state, where applicable, is shown in the Schedule below.

If you allow us to examine and audit all of your records after we have applied an Audit Noncompliance Charge, we will revise your premium in accordance with our manuals and Part 5-Premium, E. (Final Premium) of this policy.

Failure to cooperate with this policy provision may result in the cancellation of your insurance coverage, as specified under the policy.

Note:

For coverage under state-approved workers compensation assigned risk plans, failure to cooperate with this policy provision may affect your eligibility for coverage.

State(s)	Schedule	Maximum Audit Noncompliance Charge Multiplier
	Basis of Audit Noncompliance Charge	
CT	Estimated Annual Premium	Up to two times





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**Workers' Compensation
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Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

CONNECTICUT APPLICATION OF WORKERS COMPENSATION INSURANCE ENDORSEMENT
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

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

Section A, "How This Insurance Applies," of Part One, "Workers Compensation Insurance," is amended to read as follows:

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

1. Injury by accident must occur during the policy period.
2. Injury by disease must be caused or aggravated by exposure during the policy period to conditions of your employment.





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**Workers' Compensation
and Employers Liability
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Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

CONNECTICUT WORKERS COMPENSATION FUNDS ENDORSEMENT

WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

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

The amount shown on the Information Page for the Connecticut workers compensation fund assessment is required of you under Section 31-345 of the Connecticut General Statutes. We will pay these assessments to the Connecticut State Treasurer. The purpose of the assessment is to finance the expenses of administering the workers compensation laws.

THE AMOUNT SHOWN ON THE INFORMATION PAGE FOR THE CONNECTICUT SECOND INJURY FUND SURCHARGE IS REQUIRED OF YOU UNDER CONNECTICUT REGULATIONS TO FINANCE THE CONNECTICUT SECOND INJURY FUND. WE WILL PAY THIS SURCHARGE TO THE CONNECTICUT STATE TREASURER.



**WORKERS' COMPENSATION INSURANCE PLAN**

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**Workers' Compensation
and Employers Liability
Insurance Policy**

Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

Endorsement Effective Date: 05/30/2020

Policy Number	Policy Period	
	From	To
ARP12002482201	05/30/2020 12:01 A.M. Standard Time at the described location	05/30/2021

CONNECTICUT NONRENEWAL AND RENEWAL ENDORSEMENT
WCIP**ITEM 1 - Named Insured and Address**

U SEAL USA LLC
125 OLD IRON ORE RD
BLOOMFIELD, CT 06002-1424

Agency

AJC INS AGENCY
1850 SILAS DEANE HWY
ROCKY HILL, CT 06067-1319

Tax ID #: 27-4348330

State ID #:

Intrastate ID:

Bureau Risk ID:

This endorsement applies because Connecticut is shown in Item 3.A. of the Information Page.
Part Six-Conditions, of the policy is revised by adding the following:

F. Nonrenewal

We may elect not to renew the policy. Unless otherwise provided by Connecticut General Statutes Annotated Section 38a-323, we will provide you at least 60 days' advance notice of our intention not to renew. Advance notice will be provided to you by one of the following methods:

1. Registered mail
2. Certified mail
3. Mail evidenced by a certificate of mailing
4. Delivered to the named insured at the address shown in the policy

Mailing such notice to you at your address, shown in Item 1., of the Information Page, will be deemed sufficient notice under this section.

The notice of intent not to renew will state or be accompanied by a statement specifying the reason for such nonrenewal.

G. Renewal

We may elect to renew the policy. In accordance with Connecticut General Statutes Annotated Section 38a-323, we will provide you at least 60 days' advance notice of our intent to renew if, compared to this policy, the terms or conditions of the renewal policy include any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles.

This conditional renewal notice will be provided to you by one of the following methods:

1. Registered mail
2. Certified mail
3. Mail evidenced by a certificate of mailing
4. Delivered to the named insured at the address shown in the policy

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WC 06 06 01 A , 10/1/2017



**WORKERS' COMPENSATION INSURANCE PLAN**

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Renewal of Policy: ARP12002482200

Date of Mailing: 05/14/2020

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CONNECTICUT NONRENEWAL AND RENEWAL ENDORSEMENT**WCIP**

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

Mailing such notice to you at your address, shown in Item 1., of the Information Page, will be deemed sufficient notice under this section.

This conditional renewal notice will include or be accompanied by a statement clearly identifying any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles, under the renewal policy.





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CONNECTICUT ASSIGNED RISK MANDATORY ARBITRATION
ENDORSEMENT FOR EMPLOYMENT STATUS DISPUTES
WCIP

ITEM 1 - Named Insured and Address	Agency
U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424	AJC INS AGENCY 1850 SILAS DEANE HWY ROCKY HILL, CT 06067-1319
Intrastate ID:	Tax ID #: 27-4348330
Bureau Risk ID:	State ID #:

This endorsement applies to the insurance provided by the policy because Connecticut is shown in Item 3.A of the Information Page.

This endorsement only applies to disputes involving policies written in the residual market.

If you elect review of employment status disputes that result from actions taken by us after the effective date of the policy, you must do so in accordance with Connecticut General Statutes, Chapter 909, which provides the process for arbitration proceedings.

This endorsement only applies to an employment status dispute between you and us where the dispute solely involves the factual determination of whether a worker should be classified as your employee, an independent contractor, or an employee of an uninsured contractor under Connecticut law, for purposes of determining workers compensation and employers liability coverage.

- You may pursue arbitration only after you have made a good faith effort to first resolve the dispute directly with us.
- Upon verification of your payment to us for the undisputed portion of premium, we will suspend collection activity of any premium in dispute while the arbitration proceedings are pending.
- The venue for arbitration will be the Connecticut county where your business is located, unless otherwise agreed to by the parties involved in the dispute.
- The cost of the proceedings, including the cost of the arbitrator(s), will be paid equally by you and us; except that each party will be responsible for its own attorney or expert witness fees and/or any additional expenses attributable to a party.
- The provisions of Chapter 909 of the Connecticut General Statutes dealing with "Arbitration Proceedings" will govern the parties, and the decision of the arbitrator will be binding, except as otherwise provided in Chapter 909.

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U SEAL USA LLC
125 OLD IRON ORE RD
BLOOMFIELD, CT 06002-1424

**CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM
WORKERS COMPENSATION PREMIUM CREDIT APPLICATION (FORM NC-5000 D)**

The Contracting Classification Premium Adjustment Program is applicable to qualifying employers engaged in contracting operations.

A special premium calculation, which may result in a premium credit for you, will be based on average hourly pay rates for each classification of contracting operations. In order that your premium may be correctly established, please return the completed premium credit application, as set out on the reverse side of this letter, to:

NCCI
Customer Service Center
901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362

NCCI will advise us of any premium credit applicable.

If NCCI does not receive this application within 180 days after policy inception, your premium calculation will not reflect any possible premium credit.

For each applicable classification (both contracting and noncontracting) covering your company's operations in the state that this credit is being applied for (please note that each state that offers this credit requires a separate application), report the total payroll (excluding overtime premium pay, pay in excess of payroll amount charged to partners and sole proprietors as shown on the state rate pages, as well as the entire pay for any exempt sole proprietor, partner, or officer), and the corresponding total number of hours worked for the third calendar quarter (July, August, September) of the year preceding your policy effective date.

- Note #1: If you did not engage in contracting operations during the third calendar quarter, the requested information to be provided should, then, be for the last complete calendar quarter prior to the policy effective date of your workers compensation policy.
- Note #2: If you are a new business (no prior operations), submit the requested information for the first complete calendar quarter following the policy effective date of your workers compensation policy when available.
- Note #3: In the absence of specific records for salaried employees, you should assume that each individual worked 40 hours per week.

Please preserve your payroll records that formed the basis for this declaration, because we will be required to verify the reported information in order for any premium credit to be applied.

Thank you for your cooperation.

Sincerely,



CONTRACTING CLASSIFICATION—PREMIUM CREDIT APPLICATION

Insured: U SEAL USA LLC

STATE CREDIT BEING APPLIED FOR (NOTE: one state per application):

POLICY NUMBER: ARP12002482201

POLICY
EFFECTIVE DATE: 05/30/2020

CARRIER: Accident Fund Insurance Company of America

NOTE: Unless code(s), total wages paid, total hours worked, and calendar quarter reported are indicated and application is signed and dated, it cannot be processed. Contact your agent or carrier if assistance is desired.

[illegible]

The foregoing is based on actual wages (excluding overtime premium pay, pay in excess of payroll amount charged to partners and sole proprietors as shown on the state rate pages, as well as the entire pay for any exempt sole proprietor, partner, or officer) and hours worked as reflected in our payroll records for the complete calendar quarter.

Complete Calendar Quarter (please circle one):

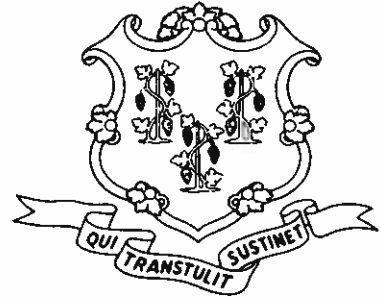
1st (1/1-3/31)	2nd (4/1-6/30)
3rd (7/1-9/30)	4th (10/1-12/31)

Calendar Year:

SIGNATURE: _____ **POSITION:** _____ **DATE:** _____



NOTICE TO EMPLOYEES



State of Connecticut Workers' Compensation Commission

Revised 10-01-2017

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer, U SEAL USA LLC

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name Accident Fund Insurance Company of America

Address PO Box 40767

Telephone 866-221-9640

City/Town Lansing

State MI Zip Code 48901-7967

Approved Medical Care Plan ☐ Yes ☒ No

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address _____ Telephone _____

City/Town _____ State _____ Zip Code _____

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you **MUST** file your compensation claim there.

When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ Telephone _____

City/Town _____ State _____ Zip Code _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted: _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).



Privacy Policy & Disclosure Notice

To our customers

Accident Fund Insurance Company of America (the "Company") does not disclose any non-public personal information about our individual policyholders, applicants, claimants, customers or former customers to any affiliated and any non-affiliated third party other than those permitted by law and only for the purpose of transacting the business of your insurance coverage or policy.

What kinds of information do we collect and from whom?

The Company obtains most of its information directly from you and/or your agent to help us serve your insurance needs, conduct Company business, provide customer service and fulfill legal and regulatory requirements. We may also review claims information and obtain medical or financial information to adjust some claims.

What do we do with the information collected about you?

The information we obtain about you is kept internal to the Company except when needed to verify the information provided, to service your policy or claim, or as required or permitted by law. The information is not available to the general public. We do not share any medical information about you or about claimants under your insurance policy to anyone other than to conduct our insurance business or as permitted by law.

What safeguards do we use?

The Company maintains physical, electronic and procedural safeguards that comply with state and federal regulations in order to guard the information about you.

For a copy of our Privacy Disclosure:

Visit our website: AssignedRiskSolutions.com

Call toll-free: 866-221-9640

Write:

Accident Fund Insurance Company of America
Office of the General Counsel
Attn: Privacy Officer
PO Box 40790
Lansing, MI 48901-7990





State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Date filed in Chairman's Office

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

(for WCC use only)

Employer (Name, Address & Zip) U SEAL USA LLC 125 OLD IRON ORE RD BLOOMFIELD, CT 06002-1424		Phone #	Carrier / Administrator Claim #		OSHA Log Case #	Report Purpose Code
SIC Code 237310		FEIN 27-4348330	Jurisdiction		Jurisdiction Claim #	
Carrier (Name, Address & Zip) Accident Fund Insurance Company of America PO Box 40767 Lansing, MI 48901-7967		Phone # 866-221-9640	Employer's Location Address (if different)		Phone #	
Policy / Self-Insured # ARP12002482201		<input type="checkbox"/> Check, if Self-Insured	Policy Period (MM/DD/YY) FROM: 05/30/2020		TO: 05/30/2021	
Employee: Last Name		First Name	Middle Name	Gender	Date Hired (MM/DD/YY)	
D.O.B. (required)		Phone #		<input type="checkbox"/> Male	Occupation / Job Title	
Address (incl. Zip)				<input type="checkbox"/> Female	Rate of Pay \$ _____ per	
				<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other	NCCI Class Code	
Date of Injury / Illness (MM/DD/YY)		Town of Injury / Illness		Physician / Health Care Provider (Name, Address & Zip)		
Time Employee Began Work <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Did Injury / Illness occur on Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Hospital (Name, Address & Zip)		
Time of Occurrence <input type="checkbox"/> cannot be determined <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Type of Injury / Illness		Initial Treatment		
Date Employer Notified (MM/DD/YY)		Part of Body Affected		<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care		
Date Disability Began (MM/DD/YY)		Type of Injury / Illness Code		<input type="checkbox"/> Minor — by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours		
Date Last Worked (MM/DD/YY)		Part of Body Affected Code		<input type="checkbox"/> Minor — by Clinic / Hospital <input type="checkbox"/> Future Major Medical — Lost Time Anticipated		
Date Return(ed) to Work (MM/DD/YY)		Were Safeguards or Safety Equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Administrator Notified (MM/DD/YY)		
If Fatal, Date of Death (MM/DD/YY)		If provided, were they used? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Prepared (MM/DD/YY)		
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:		How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:		Preparer's Name & Title		
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:				Phone #		
Contact Name		Cause of Injury Code				
Phone #						

