OWNER CONTROLLED INSURANCE PROGRAM
INSURANCE COST INFORMATION WORKSHEET

All Contractors, Subcontractors, and Sub-subcontractors of every tier, are required to complete this worksheet and submit as part of your bid.

Note: It is suggested that you examine your current Policies and contact your Insurance Broker before answering the following questions.

Project: _____

1. Contractor/Subcontractor/Sub-subcontractor: _____
2. Address:_____
3. Federal ID#:_____ 3a. Work Comp Bureau ID#:_____
4. Telephone Number:_____ Fax:_____ E-Mail:_____
5. Contact Name:_____

Bid Package (Name and Number): _____

6a. Contract Amount: $_____ 6b. Amount of Self Performed Work: $_____

7. Description of Work:_____
8. Awarding Contractor: _____
9. Claim Retention or Deductible Amounts (if greater than $5,000): WC_____ GL_____

A. Workers Compensation Estimated Payrolls/Premiums (attach separate sheet if necessary):

(1) Workers Compensation Classification(s)	(2) WC Class Code(s)	(3) Man-hours by Class Code	(4) Estimated Payroll	(5) Workers Compensation Premium Rate	(6) Workers Compensation Premium
Totals=>>					$

MODIFICATIONS TO WORKERS COMPENSATION PREMIUM		FACTOR	CHARGE	PREMIUM
A.	Estimated Total Premium (All Class Codes)			
B.	Increased Limit Factor-ILF (x A)			
C.	Experience Modification Factor or Merit Rating Credit (A+B) X C			
D.	Deviation (x C)			
E.	Construction Credit (x C)			
F.	Standard Premium (C+D+E)			
G.	Premium Discount (x C)			
H.	Deductible Credit (x C)			
I.	Scheduled Credit (x C)			
J.	Terrorism Risk Insurance Act			
K.	Other Applicable Factor			
L.	Second Injury Fund			
M.	Work Comp Funds Assessment			
N.	State Specific Surcharge			
O.	WC Loss Fund* (Form 1A – line e)			
P.	**TOTAL WORKERS COMPENSATION PREMIUM**			

**if WC is provided under large deductible, retrospectively rated or other loss sensitive program, contractor is required to compete Form 1A to determine WC Loss Fund for the bid.*

B. Commercial General Liability

Rating Basis: ☐ Payroll ☐ Contract Value ☐ Other: _____
☐ Per $100 ☐ per $1,000

GL Classification	GL Code	GL Rate	GL Payroll/Contract Value	Premium
			$	$
			$	$
		TOTAL:	*(B1)* $	*(B2)* $

C. Commercial Umbrella/Excess Liability

Classification	Code	Rate	Payroll/Contract Value	Premium
			$	$
			$	$
		TOTAL:	*(C1)* $	*(C2)* $

D. Builders Risk and Installation Floater

Rating Basis: ☐ Per $100 Contract Value ☐ Per $1,000 Contract Value ☐ Other: _____

Rate: _____ (D1) Contract Value: _____ (D2) Premium: _____ (D1) x (D2)

E. Total Insurance Premiums (A+B+C+D) **$_____**

F. Overhead & Profit on Insurance Premiums: 15 (F1) % **$_____** (F1) x E

G. Total Insurance Credit (D+E): **$_____**

Contractor/Subcontractor Insurance Credit Rate: (G/6b) _____

H. ADDITIONAL DOCUMENTS REQUIRED:

The following information must be provided along with this form:

a. Work Comp declaration page and rating pages
b. Experience Modification Worksheet from NCCI (or applicable) Bureau
c. General Liability declaration page and rating pages
d. Umbrella Liability declaration page and rating pages
e. 5 Years of GL and WC loss runs for any policy with a deductible / retention greater than $2,500.
f. 5 years of audited payrolls and GL exposures (payroll/receipts) for applicable policies with deductibles greater than $5,000
g. Form 1B for any contractor who has subcontracted to work to other contractors or plans to subcontract work.

WARRANTY
(If Enrolled in OCIP)

Regarding Workers Compensation, General Liability and Umbrella/Excess Liability: These coverages, as stated in the Contract Documents are provided by the Owner. The undersigned agrees and warrants:

1. The Contractor certifies that they have identified in their bid the Contractor's cost for the Workers' Compensation, General Liability and Umbrella/Excess Liability Coverages that are being provided and paid for by the Construction Manager. The contractor gives the Owner authority to audit its records for verification and to adjust the "Total Insurance Credit" and "Contractor Insurance Credit Rate", and collect any additional money associated with the adjustment, based on the actual payrolls incurred to complete the contract.

2. It is the Contractor's responsibility to notify their insurance carrier as to the existence of an Owner Controlled Insurance Program for this project and to amend their insurance policies accordingly.

3. The statements in this insurance application are true to the best of my knowledge.

4. The cost of the premiums for the non-OCIP insurance specified in the Contract will be paid for by the Contractor.

5. Any and all returns of premium, dividends, discounts or other adjustments to any OCIP policy is assigned, transferred and given absolutely to the Owner. This assignment pertains to the OCIP policies as now written and as subsequently modified, rewritten or replaced, including any additional amounts or coverages as a result thereof. Rights of cancellation of all insurance policies provided to Contractor are also assigned to the Owner. This assignment is only valid for insurance policies whose premiums have been paid by the Owner on behalf of such Contractors.

Date:_____ Name:_____
(please print)

Title:_____ Signature:_____

OWNER CONTROLLED INSURANCE PROGRAM
LOSS RATE CALCULATION WORKSHEET

Note: This is to be completed if contractor maintains WC or GL coverage subject to deductible in excess of $5,000

Project: _____

1. Contractor/Subcontractor/Sub-subcontractor: _____
2. Address:_____
3. Federal ID#:_____ 3a. Work Comp Bureau ID#:_____
4. Telephone Number:_____ Fax:_____ E-Mail:_____
5. Contact Name:_____

Bid Package (Name and Number): _____

6a. Contract Amount: $_____ 6b. Amount of Self Performed Work: $_____

7. Description of Work:_____
8. Awarding Contractor: _____
9. Claim Retention or Deductible Amounts (if greater than $5,000): WC_____ GL_____

I. WC Loss Rate Calculation *(if Applicable)*

Description	2009-10	2010-11	2011-12	2012-13	2013-14	Total
Gross WC Losses[1]						
Net WC Losses[2]						
Loss Development Factor (LDF)	1.20	1.30	1.40	1.75	2.50	
Adjusted Net WC Losses[3] *(= Net WC Losses x LDF)*						(a)
Payroll[4]						(b)
					WC Loss Rate (a / b)	(c)
					Projected Payroll for Project (from Form 1 – line A4)	(d)
					WC Loss Fund (c x d)	(e)

1. List total incurred losses for each of the past 5 policy periods.
2. Each loss in excess of the applicable deductible shall be limited to determine "Net WC Losses". Supporting carrier generated loss runs valued within 60 days of bid date must be provided.
3. For each policy period, multiply "Net WC Losses" by LDF, enter result. Sum and enter result as (a).
4. Enter total field payroll for each policy period. Sum and enter result as (b)

II. GL Loss Rate Calculation (if Applicable)

Description	2009-10	2010-11	2011-12	2012-13	2013-14	Total
Gross GL Losses[1]						
Net GL Losses[2]						
Loss Development Factor (LDF)	1.20	1.30	1.40	1.75	2.50	
Adjusted Net GL Losses[3] *(= Net GL Losses x LDF)*						(a)
Construction Value (CV) / Payroll[4]						(b)
					GL Loss Rate (a / b)	(c)
					Projected CV/Payroll for Project (from Form 1 – line B1)	(d)
					GL Loss Fund (c x d)	(e)

1. List total incurred losses for each of the past 5 policy periods.
2. Each loss in excess of the applicable deductible shall be limited to determine "Net GC Losses". Supporting carrier generated loss runs valued within 60 days of bid date must be provided.
3. For each policy period, multiply "Net WC Losses" by LDF, enter result. Sum and enter result as (a).
4. Enter total field payroll or CV as appropriate for each policy period. Sum and enter result as (b)

Fax To: Daria Ward
The Graham Company
215-599-9936

E-Mail To: kilgarriff_unit@grahamco.com

Mail To: Daria Ward
The Graham Company
The Graham Building
One Penn Square West
Philadelphia, PA 19102

OWNER CONTROLLED INSURANCE PROGRAM
LOSS RATE CALCULATION WORKSHEET

Note: This form is to be completed by any contractor who intends to subcontract any portion of the work to be performed under contract

Project: _____

1. Contractor/Subcontractor/Sub-subcontractor: _____
2. Address:_____
3. Federal ID#:_____ 3a. Work Comp Bureau ID#:_____
4. Telephone Number:_____ Fax:_____ E-Mail:_____
5. Contact Name:_____

Bid Package (Name and Number): _____

6a. Contract Amount: $_____ 6b. Amount of Self Performed Work: $_____

7. Description of Work:_____
8. Awarding Contractor: _____

	Contracting Parties & Trades	**Proposed Subcontract Amount**	**Estimated Man-hours**	**Estimated Payroll**	**Initial Insurance Cost**
Subcontractors which have been identified					
Additional Trade Packages *for which subcontractor has not been identified*	List by Trade or Function:				
Total for Contract:				a	b
Composite Insurance Cost Rate for Contract: (a ÷ b x 100)					

ENROLLMENT FORM
YALE UNIVERSITY
OWNER CONTROLLED INSURANCE PROGRAM
Request for Insurance
Construction Manager/Contractor/Subcontractor/Sub-subcontractor Information Form

COVERAGE IS NOT APPLICABLE UNTIL THIS FORM IS SUBMITTED TO AND APPROVED BY THE GRAHAM COMPANY. PLEASE FAX OR E-MAIL THIS FORM PRIOR TO STARTING WORK TO: THE GRAHAM COMPANY, THE GRAHAM BUILDING, ONE PENN SQUARE WEST, PHILADELPHIA, PA 19102,
ATTN: Daria Ward - FAX #215-599-9936 or e-mail: kilgarriff_unit@grahamco.com

GENERAL

1. Company Name: _____
2. Company Address: _____
   _____
3. Telephone: Area Code ( ) No: _____
4. Federal Employer ID # _____
5. Dun & Bradstreet #: _____

CONTRACT INFORMATION

6. Project: _____
7. Contract No: _____
8. Date Contract Awarded: _____
9.

	Project Site Representative	Insurance/Risk Manager	Claims Contact
Name:	_____	_____	_____
Address:	_____	_____	_____
Telephone:	_____	_____	_____
Fax Number:	_____	_____	_____
E-Mail Address:	_____	_____	_____

10. Brief Description of Work To Be Done:
    _____
    _____
11. Estimated Start Date of Jobsite Activities: _____
12. Estimated Completion Date of Jobsite Activities: _____

WORKERS COMPENSATION DATA

Classification	Class Code	Payroll*	Manhours*

**** Include only the estimated jobsite payrolls (manhours) under this contract to be directly performed by your company (and not by your subcontractors) for the period coverage is to be provided. In addition, please identify total expected payroll for all anticipated contracts for this project:*** _____

16. Workers Compensation Exp. Modification: _____
Anniversary Rating Date _____

17. Location of payroll records: _____

Contact: _____ Phone Number: _____

18. Estimated Contract Amount: $_____

19. Estimated Total Contract Amount for All Anticipated Contracts for this Project: _____

20. PRESENT INSURANCE COVERAGE

	Workers Compensation	Commercial General Liability	Business Automobile	Commercial Umbrella Liability
Insurer:				
Policy No.:				
Broker:				
Address:				
Account Executive:				
Telephone #:				

21. Your status on this project:

[ ] Construction Manager [ ] Contractor [ ] Subcontractor

22. If you are a Subcontractor, please indicate who you are working for: _____

23. If your firm anticipates that work to be done under your contract will be subcontracted to others, indicate the names and addresses of the firms which will act as your subcontractors (attach additional pages, if necessary):

Subcontractor	Contact Person	Phone Number	Subcontract $

24. Will your work under this contract be completed in part at any offsite location entirely dedicated to this project? If yes, describe work and provide address of offsite location: _____

_____

_____

25. Will your work under this contract include the use of aircraft or watercraft? If so, please describe:

_____

Name: _____ Date: _____
(please type or print)

_____
Signature Title

FORM 3

Yale University OCIP

OWNER CONTROLLED INSURANCE PROGRAM
ASSIGNMENT BY CONSTRUCTION MANAGER, CONTRACTOR OR SUBCONTRACTOR

In consideration of Yale University's agreement to arrange and provide insurance under an Owner Controlled Insurance Program and for other good and valuable consideration, we hereby assign to Yale University all rights of cancellation, return premiums, premium refunds, and any other monies due or to become due in connection with the Owner Controlled Insurance Program.

_____
Name of Construction Manager, Contractor or Subcontractor

_____ _____
By Date

_____
Title

YALE UNIVERSITY
OWNER CONTROLLED INSURANCE PROGRAM
NOTICE OF CONTRACT AWARD

We have awarded a contract to the following Contractor/Subcontractor:

1. Project Name: _____
2. Contractor Name:_____
3. Address:_____
4. Phone Number:_____
5. Contact Person: _____
6. E-Mail Address:_____
7. Fax Number:_____
8. Estimated Start Date:_____
9. Estimated Completion Date:_____
10. Contract Number:_____
11. Description of Work:_____
12. Contract Amount:_____
13. Contractor:_____
14. Contact Person:_____

Prior to the Approved Contractor or Subcontractor being permitted on-site, The Graham Company must receive their Enrollment Forms.

Fax To: Daria Ward
The Graham Company
215-599-9936

Mail To: Daria Ward
The Graham Company
The Graham Building
One Penn Square West
Philadelphia, PA 19102
E-Mail: kilgarriff_unit@grahamco.com

FORM 5

YALE UNIVERSITY
OWNER CONTROLLED INSURANCE PROGRAM
NOTICE OF WORK COMPLETION

1. Contractor Name and ID#: _____

2. Project: _____

3. Contract #: _____

4. Work Performed: _____

5. Date work completed: _____

_____
Signature

Fax To: Daria Ward
The Graham Company
215-599-9936

Mail To: Daria Ward
The Graham Company
The Graham Building
One Penn Square West
Philadelphia, PA 19102
E-Mail: kilgarriff_unit@grahamco.com

YALE UNIVERSITY
OWNER CONTROLLED INSURANCE PROGRAM
FORM 6: MONTHLY PAYROLL REPORT

Please list below your actual monthly wages expended by you for the preceding month.
Refer to the instructions below for completing this form.

FAX OR EMAIL TO: The Graham Company
C/O: Daria Ward, CPCU , ARM, Assistant Account Manager
1 Penn Square W Graham Bldg. Phila. Pa. 19102
Fax No: 1-215-599-9936 or email: kilgarriff_unit@grahamco.com

Name of Contractor: _____

Project: _____

INSTRUCTIONS:

1. Show the applicable Workers Comp Class Code in column 2. Use additional lines if more than one code applies.
2. Show the Description or Type of Work performed in column 3.
3. Show total Hours Worked on the Job Site during the period shown
4. Show total Straight-Time Payroll in column 4. This **includes** all Regular & Overtime pay at the Straight-Time Rate on the job site.

MONTHLY PERIOD: _____

WC CODE	DESCRIPTION OF WORK	HOURS WORKED	TOTAL STRAIGHT-TIME PAYROLL

I hereby certify that the wages above are the accurate wages for the period shown above.

Name: _____ Date: _____
(please type or print)

Signature: _____

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

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.

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)* | Phone #

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

SIC Code | FEIN

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured | Policy Period *(MM/DD/YY)* FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender ☐ Male ☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per ☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☐ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment ☐ Emergency Care

☐ Minor — by Employer ☐ Hospitalized More Than 24 Hours

☐ Minor — by Clinic / Hospital ☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

THE GRAHAM COMPANY®
INSURANCE BROKERS AND CONSULTANTS

JOB ANALYSIS FORM WITHOUT PHYSICIAN'S APPROVAL

Employee's Name				
Job Title				
Industry		Union:		
Employer	Name:			
	Address:			
	Contact Person:	Telephone Number:		
	Employment Considered: Unskilled ____ Semi-Skilled ____ Skilled ____			
Job Description	Essential Functions:			
	Other Functions:			
Earnings	Earnings:	Total Hours:		
	Hours:	Lunch:	Breaks:	
Training/Education Requirements				
Machine/Tools/ Equipment/ Work Aides				
Working Conditions (Environmental)	Inside: _____ Outside: _____ Both: _____			
	Cold: _____ Wet/Humid: _____ Noise/Vibrations: _____			
	Heat: _____ Hazards: _____ Fumes/Dust/Odor: _____			
Physical Demands	Never (N) Occasionally, 1-33% (O) Frequently, 34-66% (F) Continuously, 67-100% (C)			
(Per Work Day)	a. Standing: Surface:	l. Crouching:		
	b. Walking:	m. Bending:		
	c. Sitting:	n. Crawling Distance:		
	d. Carrying: Lbs.:	o. Reaching: Level:		
	e. Pushing: Lbs.:	p. Handling:		
	f. Lifting: Lbs.:	q. Simple Grasping:		
	g. Pulling: Lbs.:	r. Firm Grasping:		
	h. Climbing: Ht.:	s. Fine Manipulation:		
	i. Balancing:	t. Talking:		
	j. Stooping:	u. Seeing:		
	k. Kneeling:	v. Hearing		
Repetitive Actions	a. Feet: Right: _____ Left: _____ Both: _____ Operate Foot Controls			
	b. Hands: Right: _____ Left: _____ Both: _____ Operate Hand Controls			
Other Information or Comments				
Analyst	Name:	Date:	Time:	

Edition: 4/14/08

THE GRAHAM COMPANY®
INSURANCE BROKERS AND CONSULTANTS

JOB ANALYSIS FORM WITH PHYSICIAN'S APPROVAL

EMPLOYEE'S NAME			
JOB TITLE			
INDUSTRY		Union:	
EMPLOYER	Name:		
	Address:		
	Contact Person:	Telephone Number:	
	Employment Considered: Unskilled ____ Semi-Skilled ____ Skilled ____		
JOB DESCRIPTION	Essential Functions:		
	Other Functions:		
EARNINGS	Earnings:	Total Hours:	
	Hours:	Lunch:	Breaks:
TRAINING/EDUCATION REQUIREMENTS			
MACHINE/TOOLS/ EQUIPMENT/ WORK AIDES			
WORKING CONDITIONS (ENVIRONMENTAL)	Inside: _____ Outside: _____ Both: _____		
	Cold: _____ Wet/Humid: _____ Noise/Vibrations: _____		
	Heat: _____ Hazards: _____ Fumes/Dust/Odor: _____		
PHYSICAL DEMANDS (PER WORK DAY)	Never (N) Occasionally, 1-33% (O) Frequently, 34-66% (F) Continuously, 67-100% (C)		
	a. Standing: Surface:	l. Crouching:	
	b. Walking:	m. Bending:	
	c. Sitting:	n. Crawling Distance:	
	d. Carrying: Lbs.:	o. Reaching: Level:	
	e. Pushing: Lbs.:	p. Handling:	
	f. Lifting: Lbs.:	q. Simple Grasping:	
	g. Pulling: Lbs.:	r. Firm Grasping:	
	h. Climbing: Ht.:	s. Fine Manipulation:	
	i. Balancing:	t. Talking:	
	j. Stooping:	u. Seeing:	
	k. Kneeling:	v. Hearing	
REPETITIVE ACTIONS	a. Feet: Right: _____ Left: _____ Both: _____ Operate Foot Controls		
	b. Hands: Right: _____ Left: _____ Both: _____ Operate Hand Controls		
OTHER INFORMATION OR COMMENTS			
ANALYST	Name:	Date:	Time:

PHYSICIANS' APPROVAL: I have read the above Job Analysis, and based on my examination of _____ on _____, he/she is capable of performing these job duties. If he/she cannot perform the essential functions of the job, please state why._____

SIGNATURE: _____

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