

TexasMutual[®]

WORKERS' COMPENSATION INSURANCE

Dear Valued Customer:

Enclosed is our policyholder packet. Thank you for choosing Texas Mutual Insurance Company. We know you have a choice of workers' compensation carriers, and we are determined to continue to earn your business. As a policyholder-owned mutual company, Texas Mutual is singularly focused on serving you and your employees.

We work hard to help you control your premium, fight workers' compensation fraud and prevent workplace accidents. If your employees get injured on the job, our professionals are committed to helping them get well and return as productive members of the workforce.

Thank you again for your partnership. Please let us know if there is anything we can do to improve our service to you.

Sincerely,



Richard Gergasko
President & CEO



Thank you for choosing Texas Mutual Insurance Company. This brief guide will help you get the most value from your Texas Mutual coverage.

Earn dividends

Dividends reward loyal customers who share Texas Mutual's commitment to preventing workplace accidents. Visit texasmutual.com/OwnershipPays to learn more about dividends.

Understand your premium

Your annual premium is an estimate based on your payroll, the type of work your employees perform, your loss history, your safety programs and other factors. At the end of your policy period, we will review your account to determine your actual payroll and/or any operational changes during the policy year. If necessary, we will adjust your premium accordingly. You may get money back, or you may be billed.

Report injuries

- Report injuries the same day they happen, if possible. The fastest way to report injuries is at texasmutual.com. If you cannot report online, you may report by phone at (800) 859-5995, or send a completed DWC-1 form (available on our website – texasmutual.com) by fax to (877) 404-7999 or by mail to Texas Mutual Insurance Company, P.O. Box 12029, Austin, Texas 78711-2029.
 - Give the employee a copy of the injury report and the “Employee’s Rights and Responsibilities” brochure. The brochure can be located on the Texas Mutual Website or The Texas Department of Insurance Website.
 - Keep accurate records of the dates when you take any claim-related action, including when you file a Supplemental Report of Injury (DWC-6 form) or Employer’s Wage Statement (DWC-3 form). You are required to give a copy of these forms to the employee at the time of completion.
- You can complete the DWC-3 online by going to Texas Mutual Online (texasmutual.com) and clicking on the Employer Tab. This is the preferred method, but you can also complete the form manually and fax it to our office.
- If you have a network policy, you are required to give the employee a copy of the “Notice of Network Requirements” within three days of new employee hire and at the time of injury. The employer must provide employees with a notice of network requirements, which can be located on our website, in English, Spanish, or any other language common to employees. Additional network requirements can be located on our website.

Prevent workplace accidents

An investment in workplace safety is an investment in your employees and your bottom line. By preventing accidents, you can reduce your workers' compensation costs and improve your productivity. Texas Mutual is your partner in safety. Whether you need help finding free safety resources on our website or advice on a specific safety issue, we are here to help. Simply call us toll-free at 844-WORKSAFE between 8 a.m. and 5 p.m. Central Standard Time (CST) to speak with a knowledgeable, responsive safety services support center representative. You also have access to a multimedia library of 2,000 free training materials in the safety resource center at texasmutual.com.

Launch a return-to-work process

When employees miss work due to on-the-job injuries, their employers must find a way to make up for lost production. Meanwhile, injured employees must contend with the depression and financial stress that often come with being away from work. Texas Mutual works with you to get your injured employees well and back on the job. Visit texasmutual.com/safety/rtwtools.shtm for more information and free tools.

Fight fraud

Workers' compensation fraud is bad for your business. Our investigators specialize in protecting your premium dollars from the trickle-down effects of fraud. Visit the Fighting Fraud section at texasmutual.com to learn how you can help us stop those who try to cheat the system.

Save time with Texas Mutual® online

You can handle most of your workers' comp needs at texasmutual.com. Visit our website to report injuries, get free safety training materials, review claim detail reports, submit interim payroll reports and report suspected fraud.

Get telephone assistance

Use our enhanced automated phone services at (800) 859-5995 between 6 a.m. and 9 p.m. CST to:

- Verify quote and policy status, including issue date and policy period
- Check payment status, including amount and receipt date
- Retrieve return payment information, including check number and issue date
- Confirm deposit and/or premium amount due
- Verify claim number and assigned workers' compensation specialist
- Get address and fax information

Representatives are available between 8 a.m. and 5:30 p.m. CST to help with:

- Interim and final audit information
- Information and enrollment for free policyholder workshops
- Access to password-protected online services and password reset
- Workers' comp health care network information
- Any of your workers' comp needs

Did someone get injured on the job?

We hope you never experience a workplace accident, but if you do, you need to know some basic information about the claims process. Visit the Employers section at texasmutual.com, and click on Claims to learn what to do if an employee gets injured on the job.

Register for our email newsletter

Texas Mutual's free, monthly email newsletter includes tips on workplace safety, return-to-work, and other strategies for reducing your workers' comp costs and improving your productivity. To register, visit texasmutual.com/news/phenews.shtm.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] _____ in the event of
has workers' compensation insurance coverage from [name of commercial insurance company]
Texas Mutual Insurance Company
work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] _____. Any injuries or occupational diseases which occur on or after that date will be handled by [name of commercial insurance company] _____ Texas Mutual Insurance Company

_____ An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Name of the employer] _____

_____ tiene cobertura de seguros de compensación para trabajadores con Texas Mutual Insurance Company para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] _____. Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por Texas Mutual Insurance Company. Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.



NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: 1-866-EZE-OIEC (1-866-393-6432). More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

WHAT IS AN OMBUDSMAN? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has a workers' compensation adjuster's license and has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation. Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

28 TAC §276.5. Employer Notification of Ombudsman Program to Employees (Effective 9/1/13)

- (a) All employers participating in the workers' compensation system shall post notice of the Office of Injured Employee Counsel's (OIEC) Ombudsman Program. This notice shall be posted in the personnel office, if the employer has a personnel office, and in the workplace where each employee is likely to see the notice on a regular basis.
- (b) This notice of the Ombudsman Program shall be publicly posted in English, Spanish, and any other language that is common to the employer's employees.
- (c) This notice shall be the text provided by OIEC without any additional words or changes and may be obtained by:
- (1) Downloading the form on OIEC's website at: www.oiec.texas.gov; or
 - (2) Requesting the notice by calling OIEC's toll-free telephone number at: 1-866-EZE-OIEC (1-866-393-6432).



AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICINA DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel –OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que ayuda a los empleados que no cuentan con representación legal con sus reclamaciones en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: 1-866-EZE-OIEC (1-866-393-6432). Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio Web de la agencia (www.oiec.texas.gov).

PROGRAMA DE OMBUDSMAN

¿QUÉ ES UN OMBUDSMAN? Un Ombudsman es un empleado de OIEC que puede asistirle si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita. Cada Ombudsman cuenta con una licencia de ajustador de compensación para trabajadores y ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation). Una vez que el procedimiento haya sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarle con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

Código Administrativo de Texas No. 28 (28 Texas Administrative Code –TAC, por su nombre y siglas en inglés) §276.5. Aviso del Empleador sobre el Programa de Ombudsman para los Empleados (A partir de 9/1/13)

(a) Todos los empleados que participan en el sistema de compensación para trabajadores deberán mostrar el aviso sobre el Programa de Ombudsman de la Oficina de Asesoría Pública para el Empleado Lesionado (OIEC). Este aviso deberá ser mostrado en la oficina de personal, si es que el empleador cuenta con una oficina de personal, y en el área de trabajo donde cada empleado probablemente podrá ver el aviso de manera regular.

(b) Este aviso del Programa de Ombudsman deberá ser públicamente mostrado en inglés, español, y cualquier otro idioma que sea común para la población de los trabajadores del empleador.

(c) Este aviso deberá contener el texto que es proporcionado por OIEC sin ninguna palabra adicional o cambios y se puede obtener:

- (1) Descargando el formulario del sitio Web de OIEC en: www.oiec.texas.gov; o
- (2) Solicitando el aviso llamando al número de teléfono gratuito de OIEC al: 1-866-EZE-OIEC (1-866-393-6432).

First Fill

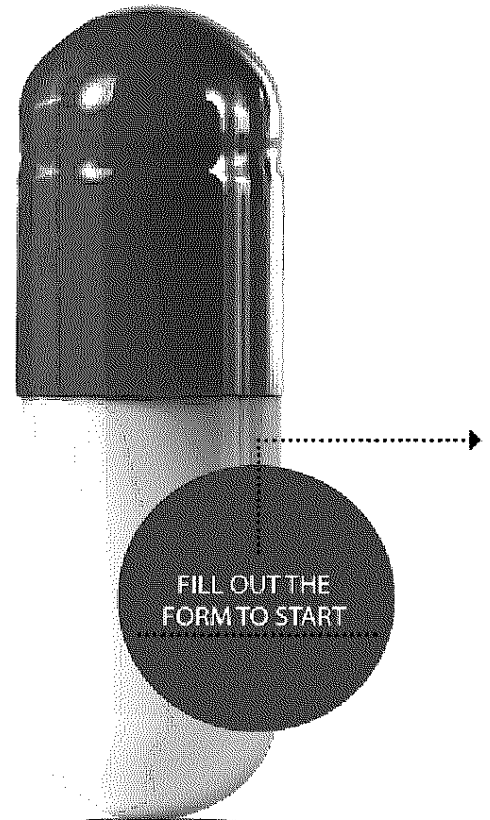
Simplifying the prescription process and helping workers take the first step toward getting well

Texas Mutual's First Fill Program enables your employees to get prescribed medication quickly after an injury occurs, even if you haven't had the opportunity to file a claim. Injured workers can get a seven-day supply for each covered prescription with a maximum of \$500 per prescription with just the First Fill form.

Complete the First Fill form on the back of this sheet and advise your employee to present it at a participating Cypress Care pharmacy.

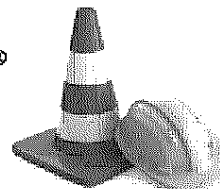
The form is valid for the first fill and cannot be used if the first prescription fill is being requested more than 10 days after the injury occurred.

If additional forms are needed, visit the employer forms section at texasmutual.com.



TexasMutual[®]
WORKERS' COMPENSATION INSURANCE
WORK SAFE, TEXAS[®]

texasmutual.com



Prescription First Fill Form

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Prescription First Fill Instructions

1. Participating Cypress Care pharmacies include Walgreens, CVS, Walmart, Kroger, Target, Costco, Sam's Club, Brookshire, HEB, and Tom Thumb. To locate other participating pharmacies, visit www.texasmutual.com/hcn/hcn.shtm or www.cypresscare.com.
2. Complete form and take to the pharmacy along with your prescription from the provider.
3. This form allows you to fill your initial prescription(s) with a maximum cost of \$500 per covered prescription and a maximum 7 day supply.
4. If you have questions, please call us at 888.220.2805, available 24 hours a day, seven days a week.

Bin #: PHARMACY TO CALL FOR BIN Group Number: TEXASMUTUALFF

Member ID:

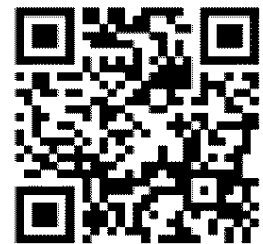
Member Name:

Employer Name:

Date of Injury:

Last 4 digits of SSN + date of injury;
No spaces (i.e. 9999050206)

Injured worker's first & last name



Policyholder Information

Pharmacy Help Desk: 888.220.2805

PLEASE NOTE: This form is only **valid within 10 days** of the injury date. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive the pharmacy card, please call us at 888.220.2805

Issuance of this letter or dispensing of a prescription does not constitute acceptance of your claim.


CYPRESS CARE
An Optum™ Company

AGENT: Please forward the Insured's copy
to them immediately.

DREISS INSURANCE AGENCY LLC
805 N MAIN ST
BOERNE, TX 78006-1625

TexasMutual[®]
Insurance Company

QUSER

3-08-2016

SAFETY SERVICES

Notice to Policyholder/Agent:

Pursuant to Texas Labor Code §411.066, Texas Mutual Insurance Company is required to notify its policyholders that accident prevention services are available from Texas Mutual Insurance Company at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene, and industrial health services. Texas Mutual Insurance Company is also required to provide return-to-work coordination services as required by Texas Labor Code §413.021 and to notify you of the availability of the return-to-work reimbursement program for employers under Texas Labor Code §413.022.

If you would like more information, contact Texas Mutual Insurance Company at 844-WORKSAFE (967-5723) and safety@texasmutual.com for accident prevention services or 844-WORKSAFE (967-5723) and safety@texasmutual.com for return-to-work coordination services. For information about these requirements call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers call the TDI-DWC at (512) 804-5000. If Texas Mutual Insurance Company fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at <http://www.tdi.texas.gov> or by mail to Texas Department of Insurance, Division of Workers' Compensation, MS-8, at 7551 Metro Center Drive, Austin, Texas 78744-1645.

In addition to the services above, Texas Mutual offers thousands of free materials in our Safety Resource Center at www.texasmutual.com. The resource center is home to an extensive library of free DVDs, posters, handouts and online videos, many of which are available in Spanish. Texas Mutual regularly enhances the resource center to provide tools that meet your ever-changing needs. We understand, however, that you may need to speak with a professional about specific safety issues. With our safety services support center, help is just a phone call away.

Simply dial 844-WORKSAFE (967-5723) between 8 a.m. and 5 p.m. CST. Our knowledgeable, responsive representatives are ready to:

- Help you access streaming videos, interactive tools and other free safety resources at www.texasmutual.com
- Identify your industry's top safety hazards and suggest best practices that address those hazards
- Conduct virtual surveys of your workplace
- Suggest specific safety programs that address your unique needs

Thank you for choosing Texas Mutual Insurance Company as your workers' compensation carrier. We value your business and will work hard to continue earning it.

IMPORTANT REMINDER

Please use the following address for all deposits/annual premium payments, endorsements, final audits and financed premium.

**Texas Mutual Insurance Company
P.O. Box 841843
Dallas, TX 75284-1843**

Please take time now to enter this information into your records.

NOTE: This address pertains ONLY to remittance payments and is not for use for other general correspondence to the Texas Mutual Insurance Company .

NOTE: This address is not to be used for overnight mail. These should be sent to our physical location. We would like to request all payments be sent in a timely manner so the above address may be utilized.

March 8, 2016

DREISS INSURANCE AGENCY LLC
805 N MAIN ST
BOERNE, TX 78006-1625

Re: 5 STAR DOORS & WINDOWS, LLC
SBP-0001302698 20160309

Thank you for placing this account with Texas Mutual Insurance Company. For your records we are enclosing:

- The policyholder's original copy of the policy
- Claims reporting information and forms
- Your agency copy of the policy

We offer many online services for agents and policyholders at texasmutual.com. Our website allows you to submit applications online, manage your accounts with us, view your clients' claim information, create customized loss reports, and stay up-to-date with *Texas Mutual*[®] news and events.

As the state's leading provider of workers' compensation insurance, we strive to set the standard in Texas for service, communication, and ease of doing business. If you have any questions, please email us at underwriting@texasmutual.com, or call us at 1-800-859-5995.

Underwriting Department



WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

6210 E Highway 290
Austin, Texas 78723-1098

INFORMATION PAGE

<p>ITEM 1</p> <p>INSURED NAME AND ADDRESS</p> <p>PRODUCER 40879</p>	<p>5 STAR DOORS & WINDOWS, LLC DBA: STEVE CLARK 2951 MARINA BAY DR STE 130-218 LEAGUE CITY, TX 77573-2735</p> <p>OTHER WORKPLACES NOT SHOWN ABOVE: see attached schedule of operation. DREISS INSURANCE AGENCY LLC 805 N MAIN ST BOERNE, TX 78006-1625</p>	<p>POLICY NUMBER SBP-0001302698 20160309</p> <p>Federal Tax ID 475259571</p> <p>Bureau Number</p> <p>Branch AUSTIN</p> <p>Renewal of NEW</p> <p>Entity LIMITED LIABILITY</p> <p>Interim Adjustment QUARTERLY-33% 3</p> <p>Group</p> <p>NCCI Carrier Code 29939</p>
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ITEM 2 **The Policy Period is from: 3-09-2016 To: 3-09-2017 12:01 A.M. standard time at the insured's mailing address**

ITEM 3

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

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	\$ 500,000	Each Accident
Bodily Injury by Disease	\$ 500,000	Each Employee
Bodily Injury by Disease	\$ 500,000	Policy Limit

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here: NONE

D. This policy includes these endorsements and schedules:

See Schedule of Endorsements attached

ITEM 4

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

TOTAL ESTIMATED STANDARD PREMIUM	\$	2,891.00
WAIVER OF SUBROGATION	:	.00
INCREASED EMPLOYERS LIABILITY LIMITS	:	100.00
TOTAL PREMIUM SUBJECT TO MODIFICATIONS	:	2,991.00
PREMIUM MODIFIED TO REFLECT EXPERIENCE MOD OF ()	:	.00
PREMIUM MODIFIED TO REFLECT SCHEDULE RATING OF (.98)	:	60.00-
WORKERS' COMP HEALTH CARE NETWORK DISCOUNT (.12)	:	352.00-
DEDUCTIBLE PREMIUM	:	.00
ADMIRALTY/FELA OR L & H W	:	.00
PREMIUM DISCOUNT, IF APPLICABLE ()	:	.00
EXPENSE CONSTANT CHARGE	:	150.00
TOTAL ESTIMATED ANNUAL PREMIUM	\$	2,729.00
MINIMUM PREMIUM	250.00	
DEPOSIT PREMIUM	901.00	

Countersigned by

Issue Date: 3-08-2016

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IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact your agent.

You may call the Texas Mutual Insurance Company toll-free telephone number for information or to make a complaint at:

1-800-859-5995

You may also write to:

Texas Mutual Insurance Company
Attn: Information Services Center
6210 E Highway 290
Austin, Texas 78723-1098

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede comunicarse con su agente.

Usted puede llamar al número de teléfono gratuito del Texas Mutual Insurance Company para obtener información o para presentar una queja al:

1-800-859-5995

Usted también puede escribir a:

Texas Mutual Insurance Company
Attn: Information Services Center
6210 E Highway 290
Austin, Texas 78723-1098

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con el agente o la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

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EXTENSION OF INFORMATION PAGE

NAME AND ADDRESS OF INSURED

5 STAR DOORS & WINDOWS, LLC
DBA: STEVE CLARK
2951 MARINA BAY DR STE 130-218
LEAGUE CITY, TX 77573-2735

POLICY NUMBER

SBP-0001302698 20160309

ISSUE DATE

3-08-2016

ITEM 4 ** SCHEDULE OF OPERATIONS **
LOCATION INFORMATION

ST	LOC	CODE #	CLASSIFICATION	PREMIUM BASIS: TOTAL ESTIMATED ANNUAL REMUNERATION	RATE PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
42	00001	5462	GLAZIER-AWAY FROM SHOP-& DRIVERS	41,000.00	7.05	2,891.00
Total Estimated Standard Premium						2,891.00

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on _____ at 12:01 A.M. standard time, forms a part of

Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

Endorsement No.

DBA: STEVE CLARK

Premium \$



Authorized Representative

NCCI Carrier Code 29939

WC000001B (ED. 1-1-2015)

AGENT'S COPY

QUSER

3-08-2016

PAGE 3

EXTENSION OF INFORMATION PAGE

NAME AND ADDRESS OF INSURED

5 STAR DOORS & WINDOWS, LLC
 DBA: STEVE CLARK
 2951 MARINA BAY DR STE 130-218
 LEAGUE CITY, TX 77573-2735

POLICY NUMBER

SBP-0001302698 20160309

ISSUE DATE

3-08-2016

ITEM 4 ** SCHEDULE OF OPERATIONS **
 STATE INFORMATION

ST	CODE #	DESCRIPTION	RATE	PREMIUM ADJUSTMENTS
42	9848	EMPLOYER LIAB BALANCE TO MIN		68.00
42	9807	INCREASED LIMITS 500/500/500	.011	32.00
42	9887	SCHEDULE RATE MODIFIER	.98	60.00-
42	9874	HEALTH CARE NETWORK DISCOUNT	.12	352.00-
42	0900	EXPENSE CONSTANT		150.00
Total Premium Adjustments				162.00-
Total Estimated Annual Premium				2,729.00

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Premium \$



NCCI Carrier Code 29939

 Authorized Representative

EXTENSION OF INFORMATION PAGE

PAGE 4

NAME AND ADDRESS OF INSURED

5 STAR DOORS & WINDOWS, LLC
DBA: STEVE CLARK
2951 MARINA BAY DR STE 130-218
LEAGUE CITY, TX 77573-2735

POLICY NUMBER

SBP-0001302698 20160309

ISSUE DATE

3-08-2016

ITEM 1 ** LOCATIONS **

LOCATION
NUMBER

ADDRESS

00001

5 STAR DOORS & WINDOWS, LLC
2951 MARINA BAY DR STE 130-218
LEAGUE CITY, TX 77573-2735

FEDERAL ID: 475259571

EFFECTIVE: 3-09-2016 EXPIRES: 3-09-2017

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. SBP-0001302698 20160309 of the Texas Mutual Insurance Company

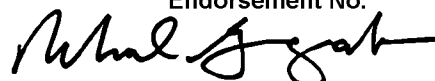
Issued to 5 STAR DOORS & WINDOWS, LLC

DBA: STEVE CLARK

Premium \$

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative

ENDORSEMENT SCHEDULE

EXTENSION OF INFORMATION PAGE

PAGE 5

NAME AND ADDRESS OF INSURED

5 STAR DOORS & WINDOWS, LLC
 DBA: STEVE CLARK
 2951 MARINA BAY DR STE 130-218
 LEAGUE CITY, TX 77573-2735

POLICY NUMBER

SBP-0001302698 20160309

ISSUE DATE

3-08-2016

ITEM 3D

** ENDORSEMENT SCHEDULE **

STATE	NUMBER	DESCRIPTION	EDITION DATE
42	TM-LRC-2008	LIMITED REIMBURSEMENT COVERAGE	1-01-2008
42	TM-PC-2003	POLICY CONDITIONS ENDORSEMENT	3-25-2003
42	TM-MV-2011	MUTUAL ENDORSEMENT FORM	1-01-2012
42	WC00 00 00C	WORKERS COMPENSATION AND EMPLO	1-01-2015
42	WC00 00 01B	WORKERS COMP/EMPLOYERS LIAB	1-01-2015
42	WC00 04 06	PREMIUM DISCOUNT	1-01-1994
42	WC00 04 14	NOTIFICATION ON CHG IN OWNRSHP	7-01-1990
42	WC00 04 22B	TERRORISM RISK INSURANCE PROG	1-01-2015
42	WC42 03 01G	TEXAS AMENDATORY	6-01-2014
42	WC42 03 08	PARTNERS/OFFICERS/OTHERS EXCL	1-01-1997
42	WC42 04 07	AUDIT PREMIUM ENDORSEMENT	3-23-2002
42	WC42 04 08A	NETWORK DISCOUNT	6-01-2014

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

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at 12:01 A.M. standard time, forms a part of

Policy No. SBP-0001302698 20160309 of the Texas Mutual Insurance Company

Issued to 5 STAR DOORS & WINDOWS, LLC

DBA: STEVE CLARK

Premium \$

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative

**LIMITED REIMBURSEMENT FOR TEXAS EMPLOYEES
INJURED IN OTHER JURISDICTIONS**

**IMPORTANT NOTICE!
PLEASE READ THIS ENDORSEMENT CAREFULLY**

This policy does not provide "other states" insurance coverage. This endorsement provides reimbursement coverage to you for those Texas employees who are described in the Texas Labor Code §§406.071-.072. Therefore the coverage is for injuries to your Texas employees that occur in another state if (i) the injury would have been compensable had it occurred in Texas and (ii) the employee has significant contacts with Texas or the employment is principally located in Texas. An employee has significant contacts with Texas if the employee was hired or recruited in Texas, and (i) the employee was injured not later than one year after the date of hire; or (ii) has worked in Texas for at least ten working days during the twelve months preceding the date of injury.

Employees hired or recruited by you outside Texas to work in another state are specifically excluded from the terms and provisions of this policy. If you conduct business in states other than Texas, you must comply with those state laws. You must promptly notify your agent before you begin work in any jurisdiction other than Texas. We are **not** authorized to provide workers' compensation insurance in any jurisdiction other than Texas. You are responsible for all of your legal obligations for your failure to comply with requirements of the workers' compensation laws of any jurisdiction other than Texas.

Part Three Other States Insurance of the policy is deleted and replaced with the following:

I. Limited Reimbursement Provision

A. How this endorsement applies

This endorsement will reimburse you after you have made payments for benefits for injuries to your Texas employees required of you in another jurisdiction. This reimbursement provision only applies to bodily injury by accident including death or bodily injury by disease including death incurred by your employee who qualifies for Texas workers' compensation benefits under Sec. 406.071 of the Texas Labor Code.

1. Bodily injury must arise out of and in the course of the injured employee's temporary employment by you in a state other than Texas.
2. Bodily injury by accident must occur during the policy period.
3. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last injurious exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
4. The employee incurring bodily injury must be eligible for Texas workers' compensation benefits and must make a written election of workers' compensation benefits in the state in which the bodily injury occurred in lieu of Texas workers' compensation benefits. You must send us written notice of such election within 10 days of receiving notice yourself. Failure to provide such notice means any reimbursement will be made in accordance with the Texas Labor Code.

B. Reimbursement

- 1. We will reimburse you for the amount you have paid as workers' compensation benefits for employees, as defined above, under the workers' compensation law of any state listed in the schedule.
- 2. We will deduct from the benefits so reimbursed any amounts we have paid as Texas benefits to the employee for the same injury for which the other jurisdiction's benefits are required.
- 3. Sections D through G of Part One of the policy will apply to reimbursement provided by this endorsement. Sections A, B, C and H of Part One of the policy will not apply to reimbursement provided by this endorsement.
- 4. We will reimburse you for reasonable attorney's fees you have paid to defend the injury claim in another jurisdiction.

II. Exclusions, Limitations and Conditions

The following conditions apply to the reimbursement afforded by this endorsement:

- 1. Nothing in this endorsement confers jurisdiction in another state or constitutes our doing business in another state.
- 2. Reimbursement will be made in Texas.
- 3. Travis County, Texas is the sole venue for any lawsuit involving reimbursement under this endorsement.
- 4. This endorsement provides reimbursement only in Texas and fully releases and indemnifies us and holds us harmless from any liability arising from your failure to obtain workers' compensation coverage in another jurisdiction.
- 5. The reimbursement provided by this endorsement excludes:
 - a. bodily injury, including death, to an employee while employed in a jurisdiction where you have secured your obligation under the workers' compensation law by other insurance or by self-insurance;
 - b. bodily injury, including death, to an employee while employed in a state where you affirmatively rejected the workers' compensation law; or
 - c. fines or penalties arising out of your failure to comply with requirements of the workers' compensation law of any state.

III. Premium

The premium basis and rates for work by Texas employees in jurisdictions other than Texas are the same as if the work had been done in Texas.

IV. Schedule

Designated States: All states of the United States of America except North Dakota, Ohio, Washington and Wyoming.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on _____ at 12:01 A.M. standard time, forms a part of

Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

DBA: **DBA: STEVE CLARK**

Premium: \$ _____

NCCI Carrier Code **29939**

Endorsement No.


 Authorized Representative

The named insured ratifies and accepts the terms and conditions of the policy to which this endorsement is attached as well as the terms listed below.

1. Policies that are on an interim reporting basis may not be financed. Texas Mutual Insurance Company may cancel coverage if it determines that interim reports have been financed in violation of this prohibition.
2. The named insured certifies that the payroll established by classification codes in the application for coverage is a true and reasonable estimate for the period of coverage requested and will promptly report any material change in payroll exposures to Texas Mutual Insurance Company. Texas Mutual Insurance Company may adjust premium for the policy upon receipt of such information.
3. The named insured and its affiliates permit Texas Mutual Insurance Company access to all of their employment information and records filed with the Texas Workforce Commission, and hereby waive the confidentiality of such information and records.
4. All obligations of the named insured are performable in Travis County, Texas and said county will be the legal venue for any suit arising from this contract. Maintenance of an action in Travis County, Texas does not work an injustice to the named insured and is in the interest of the parties, and transfer of the action would work an injustice to the parties. Any suits must be filed in Travis County, Texas.
5. If the insured defaults on payment of any premiums due under any policy issued, then all premiums due and unpaid shall become due and payable at Texas Mutual Insurance Company's offices in Austin, Travis County, Texas.
6. All information supplied to Texas Mutual Insurance Company by the named insured or its agent in the application for insurance or otherwise is true and complete; nothing material regarding its operations has been omitted; and the named insured intended Texas Mutual Insurance Company to rely on such information in issuing this policy. The named insured assumed the duty of full disclosure of such information and that Texas Mutual Insurance Company has no duty to inquire further regarding such information. The named insured is not violating any provision of the Texas Workers' Compensation Act and is not subcontracting any work to a subcontractor with the intent to avoid liability as an employer.
7. The named insured will not cause any certificate of insurance to be issued for the purpose of satisfying the workers' compensation insurance requirements of any third party, including any governmental entity, unless the remuneration paid to the individual workers performing such work is disclosed to Texas Mutual Insurance Company and included in the premium calculation of the named insured. If the named insured causes a certificate of insurance to be issued for the purpose of allowing the employees of a person other than the named insured to perform work at any job site where workers' compensation is required, and such workers are not covered by workers' compensation insurance, such action by the named insured is a material breach of this insurance policy and constitutes fraud upon Texas Mutual Insurance Company.
8. The named insured has appointed the agent whose name appears on the application as its agent in fact and agrees that any representations made on its behalf by that agent are the representations of the named insured, unless there is an express written agreement between Texas Mutual Insurance Company and the agent that the agent acts on behalf of Texas Mutual Insurance Company.
9. Acceptance of this policy with all endorsements and tender of the deposit premium constitute the insured's agreement with all of the terms and conditions thereof, and the insured's acknowledgement of the obligation to pay all premiums due for the policy.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. SBP-0001302698 20160309

of the Texas Mutual Insurance Company

Issued to 5 STAR DOORS & WINDOWS, LLC

DBA: STEVE CLARK

Premium \$

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative

MUTUALS – MEMBERSHIP AND VOTING NOTICE

The insured is notified that by virtue of this policy, he is a member of Texas Mutual Insurance Company, and is entitled to vote either in person or by proxy at any and all meetings of said Company. The Annual Meetings are held in its Home Office, 6210 E Highway 290, Austin, Texas, on the fourth Tuesday of June in each year, at 1:00 o'clock p.m. each year unless the Board of Directors of Texas Mutual Insurance Company specifies otherwise.

MUTUALS – PARTICIPATION CLAUSE WITHOUT CONTINGENT LIABILITY

No Contingent Liability: This policy is non-assessable. The policyholder is a member of the company and shall participate, to the extent and upon the conditions fixed and determined by the Board of Directors in accordance with the provisions of law, in the distributions of dividends so fixed and determined.

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at 12:01 A.M. standard time, forms a part of

Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

DBA: **STEVE CLARK**

Premium \$

NCCI Carrier Code **29939**

Endorsement No.



Authorized Representative

In return to 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 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 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;
6. Bodily injury occurring outside the United States of 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 U.S.C. Sections 901 et seq.), the Nonappropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 U.S.C. Sections 1331 et seq.), the Defense Base Act (42 U.S.C. Sections 1651-1654), the Federal Mine Safety and Health Act (30 U.S.C. 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 U.S.C. 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 or 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 U.S.C. Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, 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.

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 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 cancelled, 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 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 conflicts 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.

PREMIUM DISCOUNT ENDORSEMENT

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 Item 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

Estimated Eligible Premium

	First	Next	Next	Balance
1. <u>State</u>	\$5,000	\$95,000	\$400,000	
TEXAS	0.00	9.50	11.90	12.40

2. Average percentage discount 0.00 %

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:

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

DBA: **STEVE CLARK**

Premium \$

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

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. 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 manual.

You must report any change in ownership to us in writing within 90 days of such change. Failure to report such changes within this period may result in revision of the experience rating modification factor used to determine your premium.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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DBA: STEVE CLARK

Premium \$

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

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:

- a. The act is an act of terrorism.
- b. The act is violent or dangerous to human life, property or infrastructure.
- c. 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.
- d. 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.

“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

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
 - a. \$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.
 - b. \$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.
 - c. \$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.

- a. \$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.
 - b. \$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.
 - c. \$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
Texas	0.00	\$0.00

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(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on _____ at 12:01 A.M. standard time, forms a part of

Policy No. SBP-0001302698 20160309 of the Texas Mutual Insurance Company

Issued to 5 STAR DOORS & WINDOWS, LLC

DBA: STEVE CLARK

Premium \$

NCCI Carrier Code 29939

Endorsement No.


 Authorized Representative

TEXAS AMENDATORY ENDORSEMENT

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

GENERAL SECTION

B. Who Is Insured is amended to read:

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

D. State is amended to read:

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

PART ONE - WORKERS' COMPENSATION INSURANCE

E. Other Insurance is amended by adding this sentence:

This section only applies if you have other insurance or are self-insured for the same loss.

F. Payments You Must Make

This section is amended by deleting the words "workers' compensation" from number 4.

H. Statutory Provisions

This section is amended by deleting the words "after an injury occurs" from number 2.

PART TWO - EMPLOYERS LIABILITY INSURANCE

C. Exclusions

Sections 2 and 3 are amended to add:

This exclusion does not apply unless the violation of law caused or contributed to the bodily injury.

Section 6 is amended to read:

6. Bodily injury occurring outside the United States of 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, Mexico or Canada who is temporarily outside these countries.

D. We Will Defend

This section is amended by deleting the last sentence.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

6. Texas law allows you to make weekly payments to an injured employee in certain instances. Unless authorized by law, do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE - PREMIUM

- A. **Our Manuals** are amended by adding the sentence:

In this part, "our manuals" means manuals approved or prescribed by the Texas Department of Insurance.

- C. **Remuneration**

Number 2 is amended to read:

2. All other persons engaged in work that would make us liable under Part One (Workers' Compensation Insurance) of this policy. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured workers' compensation insurance.

- E. **Final Premium**

Number 2 is amended to read:

2. If you 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.

PART SIX - CONDITIONS

- A. **Inspection** is amended by adding this sentence:

Your failure to comply with the safety recommendations made as a result of an inspection may cause the policy to be canceled by us.

- C. **Transfer of Your Rights and Duties** is amended to read:

Your rights and duties under this policy may not be transferred without our written consent. If you die, coverage will be provided for your surviving spouse or your legal representative. This applies only with respect to their acting in the capacity as an employer and only for the workplaces listed in Items 1 and 4 on the Information Page.

- D. **Cancellation** is amended to read:

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We may also decline to renew it. We must give you written notice of cancellation or nonrenewal. That notice will be sent certified mail or delivered to you in person. A copy of the written notice will be sent to the Texas Department of Insurance – Division of Workers' Compensation.
3. Notice of cancellation or nonrenewal must be sent to you not later than the 30th day before the date on which the cancellation or nonrenewal become effective, except that we may send the notice not later than the 10th day before the date on which the cancellation or nonrenewal becomes effective if we cancel or do not renew because of:
 - a. Fraud in obtaining coverage;
 - b. Misrepresentation of the amount of payroll for purposes of premium calculation;
 - c. Failure to pay a premium when payment was due;

- d. An increase in the hazard for which you seek coverage that results from an action or omission and that would produce an increase in the rate, including an increase because of failure to comply with reasonable recommendations for loss control or to comply within a reasonable period with recommendations designed to reduce a hazard that is under your control;
 - e. A determination by the Commissioner of Insurance that the continuation of the policy would place us in violation of the law, or would be hazardous to the interests of subscribers, creditors, or the general public.
4. If another insurance company notifies the Texas Department of Insurance – Division of Workers' Compensation that it is insuring you as an employer, such notice shall be a cancellation of this policy effective when the other policy starts.

Part Seven has been added as follows:

PART SEVEN - OUR DUTY TO YOU FOR CLAIM NOTIFICATION

A. Claims Notification

We are required to notify you of any claim that is filed against your policy. Thereafter we shall notify you of any proposal to settle a claim or, on receipt of a written request from you, of an administrative or judicial proceeding relating to the resolution of a claim, including a benefit review conference conducted by the Texas Department of Insurance – Division of Workers' Compensation. You may, in writing, elect to waive this notification requirement.

We shall, on the written request from you, provide you with a list of claims charged against your policy, payments made and reserves established on each claim, and a statement explaining the effect of claims on your premium rates. We must furnish the requested information to you in writing no later than the 30th day after the date we receive your request. The information is considered to be provided on the date the information is received by the United States Postal Service or is personally delivered.

COMPLAINT NOTICE: SHOULD ANY DISPUTE ARISE ABOUT YOUR PREMIUM OR ABOUT A CLAIM THAT YOU HAVE FILED, CONTACT THE AGENT OR WRITE TO THE COMPANY THAT ISSUED THE POLICY. IF THE PROBLEM IS NOT RESOLVED, YOU MAY ALSO WRITE THE TEXAS DEPARTMENT OF INSURANCE, CONSUMER PROTECTION (111-1A), P.O. BOX 149091, AUSTIN, TEXAS 78714-9091, FAX # (512) 475-1771. THIS NOTICE OF COMPLAINT PROCEDURE IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART OR CONDITION OF THIS POLICY.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

DBA: **STEVE CLARK**

Premium \$

NCCI Carrier Code **29939**

Endorsement No.



Authorized Representative

TEXAS PARTNERS, OFFICERS AND OTHERS EXCLUSION ENDORSEMENT

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

STEVE CLARK , PRESIDENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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Endorsement No.



Authorized Representative

TEXAS – AUDIT PREMIUM AND RETROSPECTIVE PREMIUM ENDORSEMENT

Section D of Part Five of the policy is replaced by the following provision:

PART FIVE - PREMIUM

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. The billing statement or invoice for audit additional premiums and/or retrospective additional premiums establishes the date that the premium is due.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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Premium \$

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Endorsement No.



Authorized Representative

TEXAS HEALTH CARE NETWORK ENDORSEMENT

This endorsement indicates that you have elected under this policy to provide workers' compensation health care services to your injured employees through a certified workers' compensation health care network that we have either established or contracted with, as provided in Chapter 1305 of the Texas Insurance Code and in Title 28, Chapter 10 of the Texas Administrative Code.

We will provide you with information concerning the use of our certified workers' compensation health care network(s) in our service area(s) and your rights and responsibilities as a participant in our network program. This includes information describing the service area(s) applicable to you and your injured employees as required in NCCI's **Basic Manual for Workers Compensation and Employers Liability Insurance**. In accordance with Chapter 1305 Texas Insurance Code and Title 28, Chapter 10 of the Texas Administrative Code, we will also provide you with information that is required to be given to your employees, including an employee's notice of network requirements and an employee acknowledgement form.

Your premium may have been reduced because you have agreed to participate in our certified workers' compensation health care network. The amount of the premium reduction is shown on the Information Page of this policy. The reduction is estimated at the policy inception and adjusted at final audit of the policy. The reduction may be pro-rated if you elect to participate in a certified workers' compensation health care network during the policy year or if you terminate your participation in our certified workers' compensation health care network before the policy expires. The premium reduction you received may be forfeited if we determine that you have failed to provide the notice of network requirements and employee acknowledgement form to your employees in accordance with Chapter 1305.005(d) and 1305.451 Texas Insurance Code and Title 28, Chapter 10 of the Texas Administrative Code.

Minimum premium policies are not eligible for this premium reduction.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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This endorsement, effective on _____ at 12:01 A.M. standard time, forms a part of

Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

DBA: **DBA: STEVE CLARK**

Premium: \$ _____

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative



INVOICE
AGENT'S COPY

TEXAS MUTUAL INSURANCE COMPANY
CORPORATE HEADQUARTERS
AUSTIN, TEXAS 1-800-859-5995
www.texasmutual.com

INVOICE DATE 03/08/2016
INVOICE NUMBER 20847330
POLICY NUMBER 0001302698
PAGE 01 OF 01

POLICYHOLDER NAME AND ADDRESS

5 STAR DOORS & WINDOWS, LLC
2951 MARINA BAY DR STE 130-218
LEAGUE CITY, TX 77573-2735

AGENT NAME AND ADDRESS

DREISS INSURANCE AGENCY LLC
805 N MAIN ST
BOERNE, TX 78006-1625

TRANS DATE	ORIGINAL INVOICE NUMBER	ORIGINAL AMOUNT DUE	TRANSACTION DESCRIPTION	OPEN AMOUNT DUE	DUE DATE
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POLICY-EFFECTIVE DATE: 0001302698-03/09/2016

03/08/2016	20847329	901.00	Policy Issued	901.00	03/09/2016
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POLICY YEAR TOTAL \$901.00

AMOUNT DUE ON ACCOUNT \$901.00

Payments not received by their due dates may result in cancellation of your current coverage.

Detach and return this portion with your payment. Please make checks payable to Texas Mutual Insurance Company at the address below.
Payments not received by their due dates may result in cancellation of your current coverage.

TEXAS MUTUAL INSURANCE COMPANY
P.O. BOX 841843
DALLAS, TX 75284-1843
1-800-859-5995

INVOICE DATE 03/08/2016
INVOICE NUMBER 20847330
POLICY NUMBER 0001302698

AMOUNT DUE ON ACCOUNT \$901.00

AMOUNT ENCLOSED: _____

Please write your policy number on your check for prompt handling.
THANK YOU FOR YOUR BUSINESS!

5 STAR DOORS & WINDOWS, LLC
DBA: STEVE CLARK
2951 MARINA BAY DR STE 130-218
LEAGUE CITY, TX 77573-2735

TexasMutual[®]
Insurance Company

QUSER

3-08-2016

SAFETY SERVICES

Notice to Policyholder/Agent:

Pursuant to Texas Labor Code §411.066, Texas Mutual Insurance Company is required to notify its policyholders that accident prevention services are available from Texas Mutual Insurance Company at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene, and industrial health services. Texas Mutual Insurance Company is also required to provide return-to-work coordination services as required by Texas Labor Code §413.021 and to notify you of the availability of the return-to-work reimbursement program for employers under Texas Labor Code §413.022.

If you would like more information, contact Texas Mutual Insurance Company at 844-WORKSAFE (967-5723) and safety@texasmutual.com for accident prevention services or 844-WORKSAFE (967-5723) and safety@texasmutual.com for return-to-work coordination services. For information about these requirements call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers call the TDI-DWC at (512) 804-5000. If Texas Mutual Insurance Company fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at <http://www.tdi.texas.gov> or by mail to Texas Department of Insurance, Division of Workers' Compensation, MS-8, at 7551 Metro Center Drive, Austin, Texas 78744-1645.

In addition to the services above, Texas Mutual offers thousands of free materials in our Safety Resource Center at www.texasmutual.com. The resource center is home to an extensive library of free DVDs, posters, handouts and online videos, many of which are available in Spanish. Texas Mutual regularly enhances the resource center to provide tools that meet your ever-changing needs. We understand, however, that you may need to speak with a professional about specific safety issues. With our safety services support center, help is just a phone call away.

Simply dial 844-WORKSAFE (967-5723) between 8 a.m. and 5 p.m. CST. Our knowledgeable, responsive representatives are ready to:

- Help you access streaming videos, interactive tools and other free safety resources at www.texasmutual.com
- Identify your industry's top safety hazards and suggest best practices that address those hazards
- Conduct virtual surveys of your workplace
- Suggest specific safety programs that address your unique needs

Thank you for choosing Texas Mutual Insurance Company as your workers' compensation carrier. We value your business and will work hard to continue earning it.

IMPORTANT REMINDER

Please use the following address for all deposits/annual premium payments, endorsements, final audits and financed premium.

**Texas Mutual Insurance Company
P.O. Box 841843
Dallas, TX 75284-1843**

Please take time now to enter this information into your records.

NOTE: This address pertains ONLY to remittance payments and is not for use for other general correspondence to the Texas Mutual Insurance Company .

NOTE: This address is not to be used for overnight mail. These should be sent to our physical location. We would like to request all payments be sent in a timely manner so the above address may be utilized.



6210 E Highway 290
Austin, Texas 78723-1098
(512) 224-3800
1-800-859-5995

P.O. Box 12058
Austin, Texas 78711-2058
(512) 224-3800
1-800-859-5995

March 8, 2016

5 STAR DOORS & WINDOWS, LLC
DBA: STEVE CLARK
2951 MARINA BAY DR STE 130-218
LEAGUE CITY, TX 77573-2735

Re: Workers' Compensation Coverage
SBP-0001302698 20160309

Thank you for placing your account with Texas Mutual Insurance Company. For your convenience, we are enclosing a copy of your workers' compensation policy along with two claim-reporting forms you may use if one of your employees has a work-related accident.

You can also save time by reporting your injuries online at texasmutual.com. Our website also offers services that allow you to view your claim information, create your own customized loss reports, manage your workplace safety programs and stay up-to-date with *Texas Mutual*® news and events.

As the state's leading provider of workers' compensation insurance, we strive to set the standard in Texas for service, communication, and ease of doing business. If you have any questions, please email us at information@texasmutual.com or call us at 1-800-859-5995.

Underwriting Department

Texas Star Network[®]
Texas Health Care
Provider Network

Employee Information Materials

To All Employees:

Your employer is committed to your health and safety at the workplace. Our first concern is to keep injuries from happening. If you are injured, we want to help you get better and return to work as soon as it is medically safe.

Your employer has chosen the Texas Star Network® as its workers' compensation health care network. It is a network built around occupational health care providers.

We will provide services through our network of medical providers and facilities. The Texas Star Network® specializes in treating injured workers and helping them return to work.

The network includes occupational health clinics and doctors who will provide you with medical treatment. Your doctor will also manage your return to work with your employer.

Under the program, you will receive:

- a primary treating doctor;
- other occupational health services and specialists;
- emergency health care services; and
- medical care if you are working or traveling outside of the geographic services area.

The Texas Star Network® has been built to provide you with timely and quality medical care. It is easy to access. It is here to provide you with quality medical care and assist you in returning to health and a productive life.

The enclosed materials will give you information to help you through your work related injury or illness.

Dear Employee:

Your employer has chosen the Texas Star Network® to manage the health care and treatment you may receive if you are injured. The Texas Star Network® is a certified workers compensation health care network. The State of Texas has approved this network to provide care for work related injuries. This program includes a network of health care providers who are trained in treating work related injuries. They are also trained in getting people back to work safely. The Texas Star Network® service area includes greater Dallas, greater Houston, Austin/San Antonio, Amarillo, Central Texas, North East Texas, El Paso, Lubbock, Midland, Rio Grande Valley, Texarkana, Nacogdoches, Central East Texas, Abilene, Victoria, Corpus Christi, Orange, Laredo, and Wichita Falls areas. These areas are shown on the enclosed map.

If you are injured at work, tell your supervisor or employer as soon as you can. The enclosed information will help you to seek care for your injury. Also, your employer will help with any questions about how to get treatment through the Texas Star Network®. You may also contact your workers' compensation insurer for any questions about your care and treatment for a work related injury. The Texas Star Network® and your employer have formed a team to provide timely health care for injured workers. The goal is to return you to work as soon as it is safe to do so.

Your Rights and Obligations...

Choosing a Treating Doctor

If you are hurt at work and you live in the network service area, you must choose a treating doctor from the Texas Star Network®. This is required for you to receive coverage of the costs for the care of your work related injury. If at the time you are injured you belong to a health maintenance organization (HMO), you may choose your HMO primary care physician as your treating doctor. You must have chosen the doctor as your primary care doctor prior to your injury. We will approve the choice of your HMO doctor if he or she agrees to the terms of the network contract. The doctor must also agree to abide by applicable laws.

If you were injured on the job prior to September 1, 2005 and the carrier determines your injury is subject to the network, you will be advised to select a Treating Doctor from the list of participating providers in the Certified HCN. All injured workers subject to the network must live in a Certified HCN service area and must be notified, in writing, by the employer/carrier of the certified HCN requirements. You may also request a doctor you chose as your HMO primary care doctor before you were hurt. You must do this upon receipt of this notice.

If your treating doctor leaves the network we will tell you in writing. You will have the right to choose another treating doctor from the list of network doctors. If your doctor leaves the network and you have a life threatening or acute condition for which a disruption of care would be harmful to you, your doctor may request that you treat with him or her for an extra 90 days.

If you believe you live outside of the service area, you may request a service area review by calling your insurer. You should provide proof to support your belief. Within 7 days of receiving your request for review, the insurer will tell you its decision. If you do not agree with the final decision of the insurer you have the right to file a complaint with the Texas Department of Insurance. Your complaint must include your name, address, telephone number, a copy of the insurer's decision and any proof you sent to the insurer for review. A complaint form is available on the department's web site at www.tdi.texas.gov. You may also ask for a form by writing to the Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104.

When waiting for the insurer to make a decision or the Texas Department of Insurance to review your complaint, you may choose to receive all health care from the network. You may be required to pay for health care services received out of the network if it is finally decided that you do live in the network's service area.

For a list of network providers available in your area, please visit: <http://www.texasmutual.com/hcn/provdir.shtm>. The Texas Star Network online provider directory is typically updated several times a month, but no less than once a quarter.

Changing Doctors

It may happen that you become dissatisfied with your first choice of a treating doctor. You can select an alternate treating doctor from the list of network treating doctors in the service area where you live. We will not deny a choice of an alternate treating doctor. Before you can change treating doctors a second time, you must get permission from us.

Referrals

You do not have to get a referral if you have an emergency health condition. All health care services that you request will be made available by the network on a timely basis, as required by your medical condition. This includes referrals. All health care services, including referrals, will be made available no more than 21 days after you make a request.

Out-of-Network Approvals

Coventry's Network Administration Department must approve your treating doctor's out-of-network referrals (1305.006(3)) and all non-emergency, non-network providers (1305.451 (6)) before you visit those providers. If you need to request approval on a claim, please call Coventry's Network Administration Department at (888) 252-5075.

Payment for Health Care

Network doctors have agreed to look to the insurer for payment for your health care. They will not look to you for payment. If you obtain health care from a doctor who is not in the network without prior approval from the Texas Star Network®, you may have to pay for the cost of that care. You may only access non-network health care providers and still be eligible for coverage of your medical costs if one of the following situations occurs.

- Emergency care is needed. You should go to the nearest hospital or emergency care facility.
- You do not live within the service area of the network.
- Your treating doctor refers you to an out of network provider or facility. This referral must be approved by the Texas Star Network®.
- You have chosen your HMO primary care doctor. Your doctor must agree to abide by the network contract and applicable laws.

Complaints

You have the right to file a complaint with the Texas Star Network®. You may do this if you are dissatisfied with any aspect of network operations. This includes a complaint about your network doctor. It may also be a general complaint about the Texas Star Network®. Please read the enclosed Texas Star Network® Complaint Procedures, or call the Texas Star Network® Complaint Line at (800) 262-6122, to have your questions answered.

Texas Star Network®
Attention: Grievance Coordinator
3200 Highland Avenue
Downers Grove, IL 60515
Grievance Coordinator – Fax Line (630) 737-2077; ComplaintsandGrievances@cvty.com

Texas law does not permit the Texas Star Network® to retaliate against you if you file a complaint against the network. We also can not retaliate if you appeal the decision of the network. The law also does not permit us to retaliate against your treating doctor if he or she files a complaint against the network or appeals the decision of the network on your behalf. You also have the right file a complaint with the Texas Department of Insurance. The Texas Department of Insurance complaint form is available on the department's web site at www.tdi.texas.gov or you may request a form by writing to the Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104.

What to do if you are injured while on the job...

If you are injured while on the job tell your employer as soon as possible. A list of network doctors in your service area is posted at your worksite. A complete list of doctors is also available. You will be given more instructions on how to get treatment through the Texas Star Network®. Or, you may contact us directly at the following address and/or toll-free telephone number:

**Texas Star Network®
3611 Queen Palm Dr. Ste. 200
ATTN: Client Services
Tampa, Florida 33619
(800) 381-8067**

We will help you get an appointment with a network doctor.

In case of an emergency...

If you are injured and it is an emergency, you should seek treatment at the nearest emergency facility as soon as possible. This also applies if you are injured outside the service area. It also applies if you are injured after normal business hours.

After you receive emergency care, you may need ongoing care. You will need to select a network doctor from the list that your employer has given you. The doctor you choose will oversee the care you receive for your work related injury. Except for emergency care you must obtain all health care and specialist referrals through your treating doctor.

Emergency care does not need to be approved in advance. "Medical emergency" is defined by Texas law as a medical condition that comes up suddenly. There are acute symptoms that are severe enough that a reasonable person would believe that you need immediate care or you would be harmed. That harm would include your health or bodily functions being in danger or a loss of function of any body organ or part.

Non-emergency care...

Report your injury to your employer as soon as you can. Select a network treating doctor from the list given to you by your employer. Go to that doctor to be treated.

Treatment prescribed by your doctor may need to be approved in advance. You or your doctor are required to request approval from the insurer or the network for a specific treatment or services before the treatment or service is provided. You may continue to need treatment after the approved treatment is provided. For example, you may need to stay more days in the hospital than what was first approved. If so, the added treatment must be approved in advance.

Texas Star Network® Preauthorization List

This list is not intended to be comprehensive or all-inclusive; because health care is an ever-evolving science, procedures and treatments requiring prior approval will also evolve. Participating Treating Providers should therefore verify specific preauthorization requirements by referring to the updated list posted at www.texasmutual.com.

Hospital/ASC

All non-emergency hospital or ASC (inpatient, outpatient, and observation) admissions including principle scheduled procedures and length of stay. Preauthorization request should include specific hardware, implantables, external delivery system, etc. to be utilized.

Surgery/Procedures/Integral Devices

All non-emergency surgeries represented by AMA CPT codes 10010-69990 and/or G codes which represent a surgical procedure performed in a setting or place of service other than the doctor's office [POS 11]. Preauthorization request should include specified hardware, implantables, external delivery system, etc. to be utilized.

- All Botox Injections
- All spinal Injections (including but not limited to):
 - Epidural Steroid Injection
 - RFTC or Cryotherapy/Cryoablation
 - Sacral Iliac Joint Injection
 - Facet Injection
 - Medical Branch Block
- Trigger Point Injections (represented by AMA CPT 20553)
- Bone growth stimulators
- Discograms
- Implantable drug delivery system
- Investigational or experimental procedures or devices as determined by ODG or listed as an AMA Category III Code.
- Stimulator Devices (including, but not limited to):
 - *TENS units
 - *Interferential units
 - *Neuromuscular stimulators
 - *Dual units
 - *Spinal Cord Stimulator
 - *Peripheral nerve Stimulator
 - *Brain Stimulator

Physical Medicine

- All Chiropractic Treatments
- Manipulations under Anesthesia (MUA)
- All Physical Therapy/Occupational Therapy (unless requestor or rendering provider/facility is participating through Align)
- Biofeedback

Diagnostics

- All initial and Repeat MRI and CT scans
- Bone density scans
- Unless otherwise specified in this list, all repeat individual diagnostic studies (series) having a billed amount greater than \$350.
- Surface Electromyography (EMG)

Other

- Durable medical equipment (DME), Prosthetics and/or Orthotics, greater than \$500.00 billed (purchase or accumulated rental or combination of rental/purchase)
- Gym memberships
- Texas Department of Insurance, Division of Workers' Compensation (DWC) Pharmacy Closed Formulary per 28 TAC §134, Subchapter F.

Alternative Treatment (including, but not limited to):

- Acupuncture Outside ODG
- Acupressure
- Yoga

Rehab Programs (including, but not limited to):

- Work Conditioning
- Work Hardening
- Chronic Pain Management Program
- Medical Rehabilitation
- Brain and Spinal Cord Rehabilitation
- Chemical Dependency Programs
- Weight loss programs

Nursing Home (including, but not limited to):

- Skilled nursing facility, including skilled care within the same facility
- Convalescent care
- Residential care
- Assisted Living
- Group Homes

Psychological testing and Psychotherapy (including but not limited to):

- Subsequent Evaluations
- Subsequent Tests or Testing
- All Therapy
- All Biofeedback

The number to call to request one of these treatments is (888) 252-5075. If a treatment or service request is denied, we will tell you in writing. This written notice will have information about your right to request a reconsideration or appeal of the denied treatment. It will also tell you about your right to request review by an Independent Review Organization through the Texas Department of Insurance.

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual at (800) 859-5995 to notify them of my choice.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.
5. Knowingly making a false workers' compensation claim may lead to a criminal investigation that could result in criminal penalties such as fines and imprisonment.

Signature

Date

Printed Name

I live at:

Street Address

City

State

Zip Code

Name of Employer: _____

Name of Network: *Texas Star Network*[®]

Network service areas are subject to change. Call (800) 381-8067 if you need a network treating provider.

Please indicate whether this is the:

Initial Employee Notification

Injury Notification (Date of Injury: ____/____/____)

DO NOT RETURN THIS FORM TO TEXAS MUTUAL INSURANCE COMPANY UNLESS REQUESTED

NETWORK NOTICE

Texas Star Network®

To All Employees:

Your employer has chosen the Texas Star Network® to provide health care if you are injured at work. The Texas Star Network® is a certified workers' compensation health care network. This network includes medical providers that have been chosen to treat your work related injuries. They are easy to access and dedicated to giving you quality care. The following information will help you if you are injured at work.

- **If you are hurt at work and it is a life threatening emergency, you should go to the nearest emergency room. If you are injured at work after normal business hours or while working outside your service area, you should go to the nearest care facility.**

The following applies if you are hurt at work and it is not an emergency.

- Tell your employer as soon as you can.
- Choose a treating doctor from the Texas Star Network® service area where you live.
- If you are a member of a health maintenance organization (HMO) at the time you are injured, you have the right to choose your HMO primary care doctor as your treating doctor. To do this, you must have chosen the doctor as your primary care doctor before your work related injury occurred. Texas Star Network® will approve this choice if your HMO doctor agrees to abide by the terms of the network contract and comply with required laws.
- You must obtain all treatment and referrals for your injury from your treating doctor.
- Your treating doctor will be paid by your workers' compensation insurer and will not bill you for treatment.
- If you receive treatment for your injury from providers who are not in the Texas Star Network®, you may have to pay for that care.
- Information about the Texas Star Network® is available by calling toll free (800) 381-8067 or by writing to Texas Star Network®, 3611 Queen Palm Dr. Ste. 200 ATTN: Client Services, Tampa, Florida 33619.
- A list of Texas Star Network® doctors is posted at the work site and is also available from your employer.
- You may be required to get certain treatments approved in advance. Treatment that requires this is listed in your network information materials. You may also request the list from your employer.
- If the doctor leaves the network and you have a life threatening condition or an acute condition you may continue to treat with a network doctor for 90 days. This must be requested by the doctor.

TEXAS STAR NETWORK®

EMPLOYER INFORMATION FORM

Welcome To Your Workers Compensation Health Care Provider Network Program.

Your insurance carrier has chosen the Texas Star Network®, a workers compensation health care network certified by the State of Texas, to offer a workers' compensation health care provider network program. The necessary materials to implement the program are enclosed to help prepare you when an injury occurs.

Components Of Program:

- Preferred provider network
- Employee educational materials
- Toll-free first report of injury
- Utilization management (Pre-authorization)
- Telephonic and on-site case management (may include vocational services)
- Complaint process

Employer Instructions:

- Read the enclosed network educational materials and post the **"Notice of Network"**.
- Distribute network educational materials when initiating the program, within 3 days of hiring an employee and at the time of injury.
- Document the method of delivery of educational materials, to whom the materials were delivered, the location of the delivery and the date delivered.
- Be sure that all employees sign the **Employee Acknowledgment** letter and maintain it in employee's personnel file. An employee who refuses to sign remains subject to network requirements. Document a refusal to sign the acknowledgment in the employee's personnel file.
- Review the provider panel postings to ensure that the suggested medical providers are within the geographical service area of the worksite. You may call the Texas Star Network® at (800) 381-8067 for additional doctors.
- When an injury occurs, report it immediately to your claims administrator. If necessary, provide or arrange transportation of the injured employee to the network provider, or if appropriate, to the nearest emergency facility.

Texas Star Network® Service Area Map (as of February 2008)
Network service areas are subject to change



– A list of the counties in the network service area is contained on the next page –

Texas Star Network[®] Service Area County List (as of February 2008)

Network service areas are subject to change

ANDERSON	CRANE	HASKELL	MARION	SAN AUGUSTINE
ANDREWS	CROSBY	HAYS	MARTIN	SAN JACINTO
ANGELINA	DALLAM	HEMPHILL	MASON	SAN PATRICIO
ARANSAS	DALLAS	HENDERSON	MATAGORDA	SAN SABA
ARCHER	DAWSON	HIDALGO	MCCULLOCH	SCHLEICHER
ARMSTRONG	DEAF SMITH	HILL	MCLENNAN	SCURRY
ATASCOSA	DELTA	HOCKLEY	MCMULLEN	SHACKELFORD
AUSTIN	DENTON	HOOD	MEDINA	SHELBY
BAILEY	DEWITT	HOPKINS	MENARD	SHERMAN
BANDERA	DICKENS	HOUSTON	MIDLAND	SMITH
BASTROP	DONLEY	HOWARD	MILAM	SOMERVELL
BAYLOR	DUVAL	HUDSPETH	MILLS	STARR
BEE	EASTLAND	HUNT	MITCHELL	STEPHENS
BELL	ECTOR	HUTCHINSON	MONTAGUE	STERLING
BEXAR	EL PASO	IRION	MONTGOMERY	STONEWALL
BLANCO	ELLIS	JACK	MOORE	SWISHER
BORDEN	ERATH	JACKSON	MORRIS	TARRANT
BOSQUE	FALLS	JASPER	MOTLEY	TAYLOR
BOWIE	FANNIN	JEFFERSON	NACOGDOCHES	TERRY
BRAZORIA	FAYETTE	JIM HOGG	NAVARRO	THROCKMORTON
BRAZOS	FISHER	JIM WELLS	NEWTON	TITUS
BRISCOE	FLOYD	JOHNSON	NOLAN	TOM GREEN
BROOKS	FORT BEND	JONES	NUECES	TRAVIS
BROWN	FRANKLIN	KARNES	OCHILTREE	TRINITY
BURLESON	FREESTONE	KAUFMAN	OLDHAM	TYLER
BURNET	FRIO	KENDALL	ORANGE	UPSHUR
CALDWELL	GAINES	KENEDY	PALO PINTO	UPTON
CALHOUN	GALVESTON	KENT	PANOLA	UVALDE
CALLAHAN	GARZA	KERR	PARKER	VAN ZANDT
CAMERON	GILLESPIE	KIMBLE	PARMER	VICTORIA
CAMP	GLASSCOCK	KLEBERG	PECOS	WALKER
CARSON	GOLIAD	LAMAR	POLK	WALLER
CASS	GONZALES	LAMB	POTTER	WARD
CASTRO	GRAY	LAMPASAS	RAINS	WASHINGTON
CHAMBERS	GRAYSON	LAVACA	RANDALL	WEBB
CHEROKEE	GREGG	LEE	REAGAN	WHARTON
CLAY	GRIMES	LEON	REAL	WICHITA
COCHRAN	GUADALUPE	LIBERTY	RED RIVER	WILBARGER
COKE	HALE	LIMESTONE	REEVES	WILLACY
COLEMAN	HALL	LIPSCOMB	REFUGIO	WILLIAMSON
COLLIN	HAMILTON	LIVE OAK	ROBERTS	WILSON
COLORADO	HANSFORD	LLANO	ROBERTSON	WINKLER
COMAL	HARDIN	LOVING	ROCKWALL	WISE
COMANCHE	HARRIS	LUBBOCK	RUNNELS	WOOD
CONCHO	HARRISON	LYNN	RUSK	YOAKUM
COOKE	HARTLEY	MADISON	SABINE	YOUNG
CORYELL				

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filing.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>	
3. Social Security Number	4. Home Phone ()	5. Date of Birth (m-d-y)	
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>			
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>	
9. Mailing Address Street or P.O. Box			
City		State	Zip Code County
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>			
11. Number of Dependent Children		12. Spouse's Name	
13. Doctor's Name			
14. Doctor's Mailing Address (Street or P.O.Box)			
City		State	Zip Code

15. Date of Injury (m-d-y)	16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>	17. Date Lost Time Began (m-d-y)	
18. Nature of Injury*		19. Part of Body Injured or Exposed*	
20. How and Why Injury/Illness Occurred*			
21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)*	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site			
Street or P.O. Box		County	
City		State	Zip Code
24. Cause of Injury(fall, tool, machine, etc.)*			
25. List Witnesses			
26. Return to work date/or expected (m-d-y)	27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>	28. Supervisor's Name	29. Date Reported (m-d-y)
- -			- -

30. Date of Hire (m-d-y)	31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>	32. Length of Service in Current Position Months ____ Years ____	33. Length of Service in Occupation Months ____ Years ____
34. Employee Payroll Classification Code		35. Occupation of Injured Worker	
36. Rate of Pay at this Job \$ ____ Hourly \$ ____ Weekly	37. Full Work Week is: ____ Hours ____ Days	38. Last Paycheck was: \$ ____ for ____ Hours or ____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>

40. Name and Title of Person Completing Form		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ()		43. Business Location (If different from mailing address) Number and Street	
City State Zip Code		City State Zip Code	
44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company		49. Policy Number	

50. Did you request accident prevention services in past 12 months?
YES NO If yes, did you receive them? YES NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____





CLAIM #	_____
Carrier #	_____

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name	2. Employer phone #
3. Employer mailing address	
4. Insurance carrier name	
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes <input type="checkbox"/> no <input type="checkbox"/> If so, identify contact person and phone # _____	
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/>	
7. Has the employer requested RTW training from DWC or the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/>	
9. Has the employer requested accident prevention services from the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. <input type="checkbox"/>	a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
<input type="checkbox"/>	b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
<input type="checkbox"/>	c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
<input type="checkbox"/>	d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name	12. SSN	13. DOI
14. Injured worker mailing address and phone #		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)		16. First day of additional lost time or reduced wages (mm/dd/yyyy)
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes <input type="checkbox"/> no <input type="checkbox"/> If yes, the date of the 8 th day (mm/dd/yyyy) _____		
18. Date of most recent RTW _____ <input type="checkbox"/> Full duty, full pay <input type="checkbox"/> Limited duty, full pay <input type="checkbox"/> Limited duty, reduced pay	19. Has the injured worker resigned, been terminated or died? yes <input type="checkbox"/> no <input type="checkbox"/> date of resignation _____ date of termination _____ date of death _____ 19a. Reason for resignation/termination _____ 19b. Was the injured worker on limited duty when terminated? yes <input type="checkbox"/> no <input type="checkbox"/>	
20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week	21. Weekly/hourly earnings for the pay period of _____ to _____ : \$ _____ weekly or \$ _____	
Indicated hours are: <input type="checkbox"/> Increase from pre-injury <input type="checkbox"/> Same as pre-injury <input type="checkbox"/> Decrease from pre-injury	Indicated wages are: <input type="checkbox"/> Increase from pre-injury wage <input type="checkbox"/> Same a pre-injury wage <input type="checkbox"/> Decrease from pre-injury wage	

This form to be filed with: The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: Employer Injured Worker (If no longer working for the employer where injury occurred.)

Signature and Title of person completing this form

Date





Privacy Notice

March 8, 2016

Dear Policyholder:

The management and staff of Texas Mutual Insurance Company (formerly the Texas Workers' Compensation Insurance Fund) are committed to maintaining the confidentiality of your non-public, personal information. We do not disclose any non-public, personal information about our customers to anyone, except as permitted by law. We do not sell any information about our customers to mailing list companies or mass marketing organizations.

What information?

As your current workers' compensation insurance carrier, we may collect non-public, personal information directly from you or your agent. We use this information only to serve your insurance needs, conduct company business, and fulfill legal and regulatory requirements. For example, we collect information from you or your agent, such as:

- your company name, address, and federal identification number;
- your payroll, assets, and employee class codes; and
- your loss runs (history of the number and severity of workplace injuries and illnesses).

We may obtain information from your transactions and other dealings with us such as payment history and premium balance. Also, depending on the nature of your transaction with us, we may collect information from third parties, including injured workers, health care providers, other insurance companies, government agencies, information clearinghouses, courts, and other public records.

Confidentiality and Security Measures

We treat your information as strictly confidential, and we maintain physical, electronic and procedural safeguards to protect your personal information. The *Texas Mutual*® employees who have access to our customers' non-public, personal information are those who need it for business purposes. We also instruct our employees on the importance of maintaining the confidentiality of our customers' information.

At Texas Mutual Insurance Company, we respect our current and former customers' privacy. We are proud of the strong relationships we have built over the years, and we value your business.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard Gergasko", written in a cursive style.

Richard Gergasko
President

6210 E Highway 290, Austin, Texas 78723-1098
(512) 224-3800 | 1-800-859-5995 | (FAX) 1-800-359-0650 | www.texasmutual.com



WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

6210 E Highway 290
Austin, Texas 78723-1098

INFORMATION PAGE

<p>ITEM 1</p> <p>INSURED NAME AND ADDRESS</p> <p>PRODUCER 40879</p>	<p>5 STAR DOORS & WINDOWS, LLC DBA: STEVE CLARK 2951 MARINA BAY DR STE 130-218 LEAGUE CITY, TX 77573-2735</p> <p>OTHER WORKPLACES NOT SHOWN ABOVE: see attached schedule of operation. DREISS INSURANCE AGENCY LLC 805 N MAIN ST BOERNE, TX 78006-1625</p>	<p>POLICY NUMBER SBP-0001302698 20160309</p> <p>Federal Tax ID 475259571</p> <p>Bureau Number</p> <p>Branch AUSTIN</p> <p>Renewal of NEW</p> <p>Entity LIMITED LIABILITY</p> <p>Interim Adjustment QUARTERLY-33% 3</p> <p>Group</p> <p>NCCI Carrier Code 29939</p>
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ITEM 2 **The Policy Period is from: 3-09-2016 To: 3-09-2017 12:01 A.M. standard time at the insured's mailing address**

ITEM 3

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

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	\$	500,000	Each Accident
Bodily Injury by Disease	\$	500,000	Each Employee
Bodily Injury by Disease	\$	500,000	Policy Limit

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here: NONE

D. This policy includes these endorsements and schedules:

See Schedule of Endorsements attached

ITEM 4

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

TOTAL ESTIMATED STANDARD PREMIUM	\$	2,891.00
WAIVER OF SUBROGATION		.00
INCREASED EMPLOYERS LIABILITY LIMITS		100.00
TOTAL PREMIUM SUBJECT TO MODIFICATIONS		2,991.00
PREMIUM MODIFIED TO REFLECT EXPERIENCE MOD OF ()		.00
PREMIUM MODIFIED TO REFLECT SCHEDULE RATING OF (.98)		60.00-
WORKERS' COMP HEALTH CARE NETWORK DISCOUNT (.12)		352.00-
DEDUCTIBLE PREMIUM		.00
ADMIRALTY/FELA OR L & H W		.00
PREMIUM DISCOUNT, IF APPLICABLE ()		.00
EXPENSE CONSTANT CHARGE		150.00
TOTAL ESTIMATED ANNUAL PREMIUM	\$	2,729.00
MINIMUM PREMIUM	250.00	
DEPOSIT PREMIUM	901.00	

Issue Date: 3-08-2016

Countersigned by

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IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact your agent.

You may call the Texas Mutual Insurance Company toll-free telephone number for information or to make a complaint at:

1-800-859-5995

You may also write to:

Texas Mutual Insurance Company
Attn: Information Services Center
6210 E Highway 290
Austin, Texas 78723-1098

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede comunicarse con su agente.

Usted puede llamar al número de teléfono gratuito del Texas Mutual Insurance Company para obtener información o para presentar una queja al:

1-800-859-5995

Usted también puede escribir a:

Texas Mutual Insurance Company
Attn: Information Services Center
6210 E Highway 290
Austin, Texas 78723-1098

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con el agente o la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

PAGE 2

EXTENSION OF INFORMATION PAGE

NAME AND ADDRESS OF INSURED

5 STAR DOORS & WINDOWS, LLC
DBA: STEVE CLARK
2951 MARINA BAY DR STE 130-218
LEAGUE CITY, TX 77573-2735

POLICY NUMBER

SBP-0001302698 20160309

ISSUE DATE

3-08-2016

ITEM 4 ** SCHEDULE OF OPERATIONS **
LOCATION INFORMATION

ST	LOC	CODE #	CLASSIFICATION	PREMIUM BASIS: TOTAL ESTIMATED ANNUAL REMUNERATION	RATE PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
42	00001	5462	GLAZIER-AWAY FROM SHOP-& DRIVERS	41,000.00	7.05	2,891.00
Total Estimated Standard Premium						2,891.00

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. SBP-0001302698 20160309 of the Texas Mutual Insurance Company

Issued to 5 STAR DOORS & WINDOWS, LLC

Endorsement No.

DBA: STEVE CLARK

Premium \$



Authorized Representative

NCCI Carrier Code 29939

WC000001B (ED. 1-1-2015)

INSURED'S COPY

QUSER

3-08-2016

PAGE 3

EXTENSION OF INFORMATION PAGE

NAME AND ADDRESS OF INSURED

5 STAR DOORS & WINDOWS, LLC
 DBA: STEVE CLARK
 2951 MARINA BAY DR STE 130-218
 LEAGUE CITY, TX 77573-2735

POLICY NUMBER

SBP-0001302698 20160309

ISSUE DATE

3-08-2016

ITEM 4 ** SCHEDULE OF OPERATIONS **
 STATE INFORMATION

ST	CODE #	DESCRIPTION	RATE	PREMIUM ADJUSTMENTS
42	9848	EMPLOYER LIAB BALANCE TO MIN		68.00
42	9807	INCREASED LIMITS 500/500/500	.011	32.00
42	9887	SCHEDULE RATE MODIFIER	.98	60.00-
42	9874	HEALTH CARE NETWORK DISCOUNT	.12	352.00-
42	0900	EXPENSE CONSTANT		150.00
Total Premium Adjustments				162.00-
Total Estimated Annual Premium				2,729.00

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Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

Endorsement No.

DBA: STEVE CLARK

Premium \$

NCCI Carrier Code 29939



 Authorized Representative

EXTENSION OF INFORMATION PAGE

PAGE 4

NAME AND ADDRESS OF INSURED

5 STAR DOORS & WINDOWS, LLC
DBA: STEVE CLARK
2951 MARINA BAY DR STE 130-218
LEAGUE CITY, TX 77573-2735

POLICY NUMBER

SBP-0001302698 20160309

ISSUE DATE

3-08-2016

ITEM 1 ** LOCATIONS **

LOCATION
NUMBER

ADDRESS

00001

5 STAR DOORS & WINDOWS, LLC
2951 MARINA BAY DR STE 130-218
LEAGUE CITY, TX 77573-2735

FEDERAL ID: 475259571

EFFECTIVE: 3-09-2016 EXPIRES: 3-09-2017

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. SBP-0001302698 20160309 of the Texas Mutual Insurance Company

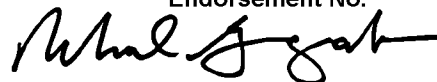
Issued to 5 STAR DOORS & WINDOWS, LLC

DBA: STEVE CLARK

Premium \$

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative

EXTENSION OF INFORMATION PAGE

PAGE 5

NAME AND ADDRESS OF INSURED

5 STAR DOORS & WINDOWS, LLC
 DBA: STEVE CLARK
 2951 MARINA BAY DR STE 130-218
 LEAGUE CITY, TX 77573-2735

POLICY NUMBER

SBP-0001302698 20160309

ISSUE DATE

3-08-2016

ITEM 3D

** ENDORSEMENT SCHEDULE **

STATE	NUMBER	DESCRIPTION	EDITION DATE
42	TM-LRC-2008	LIMITED REIMBURSEMENT COVERAGE	1-01-2008
42	TM-PC-2003	POLICY CONDITIONS ENDORSEMENT	3-25-2003
42	TM-MV-2011	MUTUAL ENDORSEMENT FORM	1-01-2012
42	WC00 00 00C	WORKERS COMPENSATION AND EMPLO	1-01-2015
42	WC00 00 01B	WORKERS COMP/EMPLOYERS LIAB	1-01-2015
42	WC00 04 06	PREMIUM DISCOUNT	1-01-1994
42	WC00 04 14	NOTIFICATION ON CHG IN OWNRSHP	7-01-1990
42	WC00 04 22B	TERRORISM RISK INSURANCE PROG	1-01-2015
42	WC42 03 01G	TEXAS AMENDATORY	6-01-2014
42	WC42 03 08	PARTNERS/OFFICERS/OTHERS EXCL	1-01-1997
42	WC42 04 07	AUDIT PREMIUM ENDORSEMENT	3-23-2002
42	WC42 04 08A	NETWORK DISCOUNT	6-01-2014

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

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Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**
DBA: STEVE CLARK

Premium \$

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative

**LIMITED REIMBURSEMENT FOR TEXAS EMPLOYEES
INJURED IN OTHER JURISDICTIONS**

**IMPORTANT NOTICE!
PLEASE READ THIS ENDORSEMENT CAREFULLY**

This policy does not provide "other states" insurance coverage. This endorsement provides reimbursement coverage to you for those Texas employees who are described in the Texas Labor Code §§406.071-.072. Therefore the coverage is for injuries to your Texas employees that occur in another state if (i) the injury would have been compensable had it occurred in Texas and (ii) the employee has significant contacts with Texas or the employment is principally located in Texas. An employee has significant contacts with Texas if the employee was hired or recruited in Texas, and (i) the employee was injured not later than one year after the date of hire; or (ii) has worked in Texas for at least ten working days during the twelve months preceding the date of injury.

Employees hired or recruited by you outside Texas to work in another state are specifically excluded from the terms and provisions of this policy. If you conduct business in states other than Texas, you must comply with those state laws. You must promptly notify your agent before you begin work in any jurisdiction other than Texas. We are **not** authorized to provide workers' compensation insurance in any jurisdiction other than Texas. You are responsible for all of your legal obligations for your failure to comply with requirements of the workers' compensation laws of any jurisdiction other than Texas.

Part Three Other States Insurance of the policy is deleted and replaced with the following:

I. Limited Reimbursement Provision

A. How this endorsement applies

This endorsement will reimburse you after you have made payments for benefits for injuries to your Texas employees required of you in another jurisdiction. This reimbursement provision only applies to bodily injury by accident including death or bodily injury by disease including death incurred by your employee who qualifies for Texas workers' compensation benefits under Sec. 406.071 of the Texas Labor Code.

1. Bodily injury must arise out of and in the course of the injured employee's temporary employment by you in a state other than Texas.
2. Bodily injury by accident must occur during the policy period.
3. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last injurious exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
4. The employee incurring bodily injury must be eligible for Texas workers' compensation benefits and must make a written election of workers' compensation benefits in the state in which the bodily injury occurred in lieu of Texas workers' compensation benefits. You must send us written notice of such election within 10 days of receiving notice yourself. Failure to provide such notice means any reimbursement will be made in accordance with the Texas Labor Code.

B. Reimbursement

- 1. We will reimburse you for the amount you have paid as workers' compensation benefits for employees, as defined above, under the workers' compensation law of any state listed in the schedule.
- 2. We will deduct from the benefits so reimbursed any amounts we have paid as Texas benefits to the employee for the same injury for which the other jurisdiction's benefits are required.
- 3. Sections D through G of Part One of the policy will apply to reimbursement provided by this endorsement. Sections A, B, C and H of Part One of the policy will not apply to reimbursement provided by this endorsement.
- 4. We will reimburse you for reasonable attorney's fees you have paid to defend the injury claim in another jurisdiction.

II. Exclusions, Limitations and Conditions

The following conditions apply to the reimbursement afforded by this endorsement:

- 1. Nothing in this endorsement confers jurisdiction in another state or constitutes our doing business in another state.
- 2. Reimbursement will be made in Texas.
- 3. Travis County, Texas is the sole venue for any lawsuit involving reimbursement under this endorsement.
- 4. This endorsement provides reimbursement only in Texas and fully releases and indemnifies us and holds us harmless from any liability arising from your failure to obtain workers' compensation coverage in another jurisdiction.
- 5. The reimbursement provided by this endorsement excludes:
 - a. bodily injury, including death, to an employee while employed in a jurisdiction where you have secured your obligation under the workers' compensation law by other insurance or by self-insurance;
 - b. bodily injury, including death, to an employee while employed in a state where you affirmatively rejected the workers' compensation law; or
 - c. fines or penalties arising out of your failure to comply with requirements of the workers' compensation law of any state.

III. Premium

The premium basis and rates for work by Texas employees in jurisdictions other than Texas are the same as if the work had been done in Texas.

IV. Schedule

Designated States: All states of the United States of America except North Dakota, Ohio, Washington and Wyoming.

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This endorsement, effective on _____ at 12:01 A.M. standard time, forms a part of

Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

DBA: **DBA: STEVE CLARK**

Premium: \$ _____

NCCI Carrier Code **29939**

Endorsement No.


 Authorized Representative

The named insured ratifies and accepts the terms and conditions of the policy to which this endorsement is attached as well as the terms listed below.

1. Policies that are on an interim reporting basis may not be financed. Texas Mutual Insurance Company may cancel coverage if it determines that interim reports have been financed in violation of this prohibition.
2. The named insured certifies that the payroll established by classification codes in the application for coverage is a true and reasonable estimate for the period of coverage requested and will promptly report any material change in payroll exposures to Texas Mutual Insurance Company. Texas Mutual Insurance Company may adjust premium for the policy upon receipt of such information.
3. The named insured and its affiliates permit Texas Mutual Insurance Company access to all of their employment information and records filed with the Texas Workforce Commission, and hereby waive the confidentiality of such information and records.
4. All obligations of the named insured are performable in Travis County, Texas and said county will be the legal venue for any suit arising from this contract. Maintenance of an action in Travis County, Texas does not work an injustice to the named insured and is in the interest of the parties, and transfer of the action would work an injustice to the parties. Any suits must be filed in Travis County, Texas.
5. If the insured defaults on payment of any premiums due under any policy issued, then all premiums due and unpaid shall become due and payable at Texas Mutual Insurance Company's offices in Austin, Travis County, Texas.
6. All information supplied to Texas Mutual Insurance Company by the named insured or its agent in the application for insurance or otherwise is true and complete; nothing material regarding its operations has been omitted; and the named insured intended Texas Mutual Insurance Company to rely on such information in issuing this policy. The named insured assumed the duty of full disclosure of such information and that Texas Mutual Insurance Company has no duty to inquire further regarding such information. The named insured is not violating any provision of the Texas Workers' Compensation Act and is not subcontracting any work to a subcontractor with the intent to avoid liability as an employer.
7. The named insured will not cause any certificate of insurance to be issued for the purpose of satisfying the workers' compensation insurance requirements of any third party, including any governmental entity, unless the remuneration paid to the individual workers performing such work is disclosed to Texas Mutual Insurance Company and included in the premium calculation of the named insured. If the named insured causes a certificate of insurance to be issued for the purpose of allowing the employees of a person other than the named insured to perform work at any job site where workers' compensation is required, and such workers are not covered by workers' compensation insurance, such action by the named insured is a material breach of this insurance policy and constitutes fraud upon Texas Mutual Insurance Company.
8. The named insured has appointed the agent whose name appears on the application as its agent in fact and agrees that any representations made on its behalf by that agent are the representations of the named insured, unless there is an express written agreement between Texas Mutual Insurance Company and the agent that the agent acts on behalf of Texas Mutual Insurance Company.
9. Acceptance of this policy with all endorsements and tender of the deposit premium constitute the insured's agreement with all of the terms and conditions thereof, and the insured's acknowledgement of the obligation to pay all premiums due for the policy.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. SBP-0001302698 20160309

of the Texas Mutual Insurance Company

Issued to 5 STAR DOORS & WINDOWS, LLC

DBA: STEVE CLARK

Premium \$

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative

MUTUALS – MEMBERSHIP AND VOTING NOTICE

The insured is notified that by virtue of this policy, he is a member of Texas Mutual Insurance Company, and is entitled to vote either in person or by proxy at any and all meetings of said Company. The Annual Meetings are held in its Home Office, 6210 E Highway 290, Austin, Texas, on the fourth Tuesday of June in each year, at 1:00 o'clock p.m. each year unless the Board of Directors of Texas Mutual Insurance Company specifies otherwise.

MUTUALS – PARTICIPATION CLAUSE WITHOUT CONTINGENT LIABILITY

No Contingent Liability: This policy is non-assessable. The policyholder is a member of the company and shall participate, to the extent and upon the conditions fixed and determined by the Board of Directors in accordance with the provisions of law, in the distributions of dividends so fixed and determined.

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This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

DBA: **STEVE CLARK**

Premium \$

NCCI Carrier Code **29939**

Endorsement No.



Authorized Representative

In return to 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 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 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;
6. Bodily injury occurring outside the United States of 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 U.S.C. Sections 901 et seq.), the Nonappropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 U.S.C. Sections 1331 et seq.), the Defense Base Act (42 U.S.C. Sections 1651-1654), the Federal Mine Safety and Health Act (30 U.S.C. 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 U.S.C. 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 or 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 U.S.C. Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, 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.

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 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 cancelled, 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 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 conflicts 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.

PREMIUM DISCOUNT ENDORSEMENT

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 Item 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

Estimated Eligible Premium

	First	Next	Next	Balance
1. <u>State</u>	\$5,000	\$95,000	\$400,000	
TEXAS	0.00	9.50	11.90	12.40

2. Average percentage discount 0.00 %

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:

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

DBA: **STEVE CLARK**

Premium \$

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

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. 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 manual.

You must report any change in ownership to us in writing within 90 days of such change. Failure to report such changes within this period may result in revision of the experience rating modification factor used to determine your premium.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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at 12:01 A.M. standard time, forms a part of

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Issued to 5 STAR DOORS & WINDOWS, LLC

DBA: STEVE CLARK

Premium \$

NCCI Carrier Code 29939

Endorsement No.



Authorized Representative

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

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:

- a. The act is an act of terrorism.
- b. The act is violent or dangerous to human life, property or infrastructure.
- c. 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.
- d. 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.

“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

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
 - a. \$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.
 - b. \$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.
 - c. \$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.

- a. \$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.
 - b. \$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.
 - c. \$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
Texas	0.00	\$0.00

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(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on _____ at 12:01 A.M. standard time, forms a part of

Policy No. SBP-0001302698 20160309 of the Texas Mutual Insurance Company

Issued to 5 STAR DOORS & WINDOWS, LLC

DBA: STEVE CLARK

Premium \$

Endorsement No.



Authorized Representative

NCCI Carrier Code 29939

TEXAS AMENDATORY ENDORSEMENT

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

GENERAL SECTION

B. **Who Is Insured** is amended to read:

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

D. **State** is amended to read:

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

PART ONE - WORKERS' COMPENSATION INSURANCE

E. **Other Insurance** is amended by adding this sentence:

This section only applies if you have other insurance or are self-insured for the same loss.

F. **Payments You Must Make**

This section is amended by deleting the words "workers' compensation" from number 4.

H. **Statutory Provisions**

This section is amended by deleting the words "after an injury occurs" from number 2.

PART TWO - EMPLOYERS LIABILITY INSURANCE

C. **Exclusions**

Sections 2 and 3 are amended to add:

This exclusion does not apply unless the violation of law caused or contributed to the bodily injury.

Section 6 is amended to read:

6. Bodily injury occurring outside the United States of 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, Mexico or Canada who is temporarily outside these countries.

D. **We Will Defend**

This section is amended by deleting the last sentence.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

6. Texas law allows you to make weekly payments to an injured employee in certain instances. Unless authorized by law, do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE - PREMIUM

- A. **Our Manuals** are amended by adding the sentence:

In this part, "our manuals" means manuals approved or prescribed by the Texas Department of Insurance.

- C. **Remuneration**

Number 2 is amended to read:

2. All other persons engaged in work that would make us liable under Part One (Workers' Compensation Insurance) of this policy. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured workers' compensation insurance.

- E. **Final Premium**

Number 2 is amended to read:

2. If you 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.

PART SIX - CONDITIONS

- A. **Inspection** is amended by adding this sentence:

Your failure to comply with the safety recommendations made as a result of an inspection may cause the policy to be canceled by us.

- C. **Transfer of Your Rights and Duties** is amended to read:

Your rights and duties under this policy may not be transferred without our written consent. If you die, coverage will be provided for your surviving spouse or your legal representative. This applies only with respect to their acting in the capacity as an employer and only for the workplaces listed in Items 1 and 4 on the Information Page.

- D. **Cancellation** is amended to read:

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We may also decline to renew it. We must give you written notice of cancellation or nonrenewal. That notice will be sent certified mail or delivered to you in person. A copy of the written notice will be sent to the Texas Department of Insurance – Division of Workers' Compensation.
3. Notice of cancellation or nonrenewal must be sent to you not later than the 30th day before the date on which the cancellation or nonrenewal become effective, except that we may send the notice not later than the 10th day before the date on which the cancellation or nonrenewal becomes effective if we cancel or do not renew because of:
 - a. Fraud in obtaining coverage;
 - b. Misrepresentation of the amount of payroll for purposes of premium calculation;
 - c. Failure to pay a premium when payment was due;

- d. An increase in the hazard for which you seek coverage that results from an action or omission and that would produce an increase in the rate, including an increase because of failure to comply with reasonable recommendations for loss control or to comply within a reasonable period with recommendations designed to reduce a hazard that is under your control;
 - e. A determination by the Commissioner of Insurance that the continuation of the policy would place us in violation of the law, or would be hazardous to the interests of subscribers, creditors, or the general public.
4. If another insurance company notifies the Texas Department of Insurance – Division of Workers' Compensation that it is insuring you as an employer, such notice shall be a cancellation of this policy effective when the other policy starts.

Part Seven has been added as follows:

PART SEVEN - OUR DUTY TO YOU FOR CLAIM NOTIFICATION

A. Claims Notification

We are required to notify you of any claim that is filed against your policy. Thereafter we shall notify you of any proposal to settle a claim or, on receipt of a written request from you, of an administrative or judicial proceeding relating to the resolution of a claim, including a benefit review conference conducted by the Texas Department of Insurance – Division of Workers' Compensation. You may, in writing, elect to waive this notification requirement.

We shall, on the written request from you, provide you with a list of claims charged against your policy, payments made and reserves established on each claim, and a statement explaining the effect of claims on your premium rates. We must furnish the requested information to you in writing no later than the 30th day after the date we receive your request. The information is considered to be provided on the date the information is received by the United States Postal Service or is personally delivered.

COMPLAINT NOTICE: SHOULD ANY DISPUTE ARISE ABOUT YOUR PREMIUM OR ABOUT A CLAIM THAT YOU HAVE FILED, CONTACT THE AGENT OR WRITE TO THE COMPANY THAT ISSUED THE POLICY. IF THE PROBLEM IS NOT RESOLVED, YOU MAY ALSO WRITE THE TEXAS DEPARTMENT OF INSURANCE, CONSUMER PROTECTION (111-1A), P.O. BOX 149091, AUSTIN, TEXAS 78714-9091, FAX # (512) 475-1771. THIS NOTICE OF COMPLAINT PROCEDURE IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART OR CONDITION OF THIS POLICY.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

DBA: **STEVE CLARK**

Premium \$

NCCI Carrier Code **29939**

Endorsement No.



Authorized Representative

TEXAS PARTNERS, OFFICERS AND OTHERS EXCLUSION ENDORSEMENT

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

STEVE CLARK , PRESIDENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on

at 12:01 A.M. standard time, forms a part of

Policy No. SBP-0001302698 20160309 of the Texas Mutual Insurance Company

Issued to 5 STAR DOORS & WINDOWS , LLC

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Premium \$

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Endorsement No.



Authorized Representative

TEXAS – AUDIT PREMIUM AND RETROSPECTIVE PREMIUM ENDORSEMENT

Section D of Part Five of the policy is replaced by the following provision:

PART FIVE - PREMIUM

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. The billing statement or invoice for audit additional premiums and/or retrospective additional premiums establishes the date that the premium is due.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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at 12:01 A.M. standard time, forms a part of

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Endorsement No.



Authorized Representative

TEXAS HEALTH CARE NETWORK ENDORSEMENT

This endorsement indicates that you have elected under this policy to provide workers' compensation health care services to your injured employees through a certified workers' compensation health care network that we have either established or contracted with, as provided in Chapter 1305 of the Texas Insurance Code and in Title 28, Chapter 10 of the Texas Administrative Code.

We will provide you with information concerning the use of our certified workers' compensation health care network(s) in our service area(s) and your rights and responsibilities as a participant in our network program. This includes information describing the service area(s) applicable to you and your injured employees as required in NCCI's **Basic Manual for Workers Compensation and Employers Liability Insurance**. In accordance with Chapter 1305 Texas Insurance Code and Title 28, Chapter 10 of the Texas Administrative Code, we will also provide you with information that is required to be given to your employees, including an employee's notice of network requirements and an employee acknowledgement form.

Your premium may have been reduced because you have agreed to participate in our certified workers' compensation health care network. The amount of the premium reduction is shown on the Information Page of this policy. The reduction is estimated at the policy inception and adjusted at final audit of the policy. The reduction may be pro-rated if you elect to participate in a certified workers' compensation health care network during the policy year or if you terminate your participation in our certified workers' compensation health care network before the policy expires. The premium reduction you received may be forfeited if we determine that you have failed to provide the notice of network requirements and employee acknowledgement form to your employees in accordance with Chapter 1305.005(d) and 1305.451 Texas Insurance Code and Title 28, Chapter 10 of the Texas Administrative Code.

Minimum premium policies are not eligible for this premium reduction.

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on _____ at 12:01 A.M. standard time, forms a part of


Policy No. **SBP-0001302698 20160309** of the Texas Mutual Insurance Company

Issued to **5 STAR DOORS & WINDOWS, LLC**

DBA: **DBA: STEVE CLARK**

Premium: \$ _____

NCCI Carrier Code 29939

Endorsement No.


Authorized Representative



INVOICE
INSURED COPY

TEXAS MUTUAL INSURANCE COMPANY
CORPORATE HEADQUARTERS
AUSTIN, TEXAS 1-800-859-5995
www.texasmutual.com

INVOICE DATE 03/08/2016
INVOICE NUMBER 20847330
POLICY NUMBER 0001302698
PAGE 01 OF 01

POLICYHOLDER NAME AND ADDRESS

5 STAR DOORS & WINDOWS, LLC
2951 MARINA BAY DR STE 130-218
LEAGUE CITY, TX 77573-2735

AGENT NAME AND ADDRESS

DREISS INSURANCE AGENCY LLC
805 N MAIN ST
BOERNE, TX 78006-1625

TRANS DATE	ORIGINAL INVOICE NUMBER	ORIGINAL AMOUNT DUE	TRANSACTION DESCRIPTION	OPEN AMOUNT DUE	DUE DATE
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POLICY-EFFECTIVE DATE: 0001302698-03/09/2016					
03/08/2016	20847329	901.00	Policy Issued	901.00	03/09/2016

POLICY YEAR TOTAL \$901.00

AMOUNT DUE ON ACCOUNT \$901.00

Payments not received by their due dates may result in cancellation of your current coverage.

Detach and return this portion with your payment. Please make checks payable to Texas Mutual Insurance Company at the address below.
Payments not received by their due dates may result in cancellation of your current coverage.

TEXAS MUTUAL INSURANCE COMPANY
P.O. BOX 841843
DALLAS, TX 75284-1843
1-800-859-5995

INVOICE DATE 03/08/2016
INVOICE NUMBER 20847330
POLICY NUMBER 0001302698

AMOUNT DUE ON ACCOUNT \$901.00

AMOUNT ENCLOSED: _____

Please write your policy number on your check for prompt handling.
THANK YOU FOR YOUR BUSINESS!