Together Achieving Team Excellence
COUNTY SCHOOL DISTRICT
COLDWATER • EAST TATE • INDEPENDENCE • STRAYHORN

Business office
574 Parkway Street
Coldwater, MS 38618
P (662)562-5861 F (662)622-7406
www.tatecountyschools.org

To: Tate County District Employees

From: Sandy Patton, Director of Finance

Date: April 21, 2022

RE: Worker Compensation Claim Forms

The attached documents must be completed when a Workers' Compensation claim is being filed.

The **MWCC-Workers' Compensation – First Report of Injury or Illness** and the **Choice of Physician** form must be e-mailed or faxed to the business office as soon after the incident occurs as possible. These documents are needed to start the claim process with our insurance carrier. These forms should be taken with the injured to the doctor's office because our insurance carrier's contact information and policy number is on the forms.

Within three days of the incident the following forms must be sent to the business office:

1. First Report of Injury
2. Choice of Physician form
3. Handwritten Statements from Witness Detailing the Accident

If you have any questions, please contact me at 662-562-5861 or by e-mail at spatton@tcsdms.org.

Thank you,

Sandy Patton

Sandy Patton

# MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
TATE COUNTY SCHOOL DISTRICT
574 PARKWAY STREET
COLDWATER, MS 38618

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE # 662-562-5861

SIC CODE

EMPLOYER FEIN

## CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)
Berkley Southeast Insurance Group
PO Box 5658
Meridian, MS 39302-5658
1-855-802-5273 Fax 1-866-814-7532

POLICY PERIOD
10/1/2022 TO 9/30/2023

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY/SELF-INSURED NUMBER
4419864-43

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

## EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
☐ MALE (M)
☐ FEMALE (F)
☐ UNKNOWN (U)

MARITAL STATUS
☐ UNMARRIED/SINGLE/DIVORCED (U)
☐ MARRIED (M)
☐ SEPARATED (S)
☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

# OF DEPENDENTS

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

#DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

## OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
- NO MEDICAL TREATMENT (0) ☐
- MINOR: BY EMPLOYER (1) ☐
- MINOR CLINIC/HOSP (2) ☐
- EMERGENCY CARE (3) ☐
- HOSPITALIZED > 24 HRS (4) ☐
- FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) ☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE

PHONE NUMBER


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# NOTICE OF PHYSICIAN CHOICE
# AND MEDICAL AUTHORIZATION

Claimant's Name ______________________________________________

Claimant's Social Security Number XXX-XX-__________

Employer's Name ______________________________________________

Date of Injury ______________________________________________

MWCC No. ______________________________________________

I am claiming to have sustained an injury involving my ______________________________

I am ____ am not ____ claiming that my medical condition is work-related.

If work-related:

> I understand that under the Mississippi Workers' Compensation Law, I have the right to choose one physician to render treatment to me. I can either accept the physician to whom I am sent by my employer or choose someone else on my own.
>
> I also understand that any referral to any other doctor must be made by my one chosen physician.
>
> I also understand that my employer (or Workers' Compensation Carrier) must approve any physician change, and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

_____ I accept as my choice of physician my employer's tender of treatment by Dr. ______________

_____ I elect to choose my own physician to render treatment and that choice is Dr. ______________

I also hereby authorize any doctor, physician, psychologist, hospital, or other provider of medical and related care to release unto and/or discuss with my employer, their agents, employees, workers' compensation insurance carrier, third party administrator, or attorney, all medical information including reports, psychological test results, opinions, records, x-rays, x-ray reports, laboratory reports, nurse's notes, physicians' orders, and any and all other documents relating to any examination or treatment of myself.

I hereby agree that a copy of this authorization form shall have the same force and effect as the original thereof and further agree that this authorization shall remain valid so long as the claim against my above-named employer is pending.

______________________________
Claimant's signature

Date: __________________________

Witnessed by:

______________________________

______________________________

# WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

## GENERAL INFORMATION

**EMPLOYER (NAME & ADDRESS INCL ZIP)** - The name and address of the entity employing or statutorily responsible for the employee.

**SIC CODE** - The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

**EMPLOYER FEIN** - Employer's Federal Employer Identification Number.

**CARRIER/ADMINISTRATOR CLAIM NUMBER** - Carrier's claim or file number.

**REPORT PURPOSE CODE** - A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

**JURISDICTION** - State in which you are filing the claim (Mississippi).

**JURISDICTION CLAIM NUMBER** - Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

**INSURED REPORT NUMBER** - The number, if any, used by the employer to identify the claim.

**EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)** - The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

**LOCATION #/ PHONE #** - The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

**CARRIER (NAME, ADDRESS & PHONE NO)** - The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

**POLICY PERIOD** - The date that the contract/policy under which the claim occurred began and expired.

**CHECK IF APPROPRIATE (SELF-INSURANCE)** - An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

**CLAIMS ADMINISTRATOR** - The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

**CARRIER FEIN** - Carrier's Federal Employer Identification Number.

**POLICY/ SELF-INSURED NUMBER** - The number assigned by the carrier to the insurance contract/policy for the employer, or any similar number assigned to a self-insured employer.

**ADMINISTRATOR FEIN** - Federal Employer Identification Number of Administrator.

**AGENT NAME & CODE NUMBER** - The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

## EMPLOYEE/WAGE INFORMATION

**NAME (LAST, FIRST MIDDLE)** - Employee's legally recognized name.

**ADDRESS** - The mailing address used by the employee.

**PHONE** - A telephone number where the employee can be reached.

**DATE OF BIRTH** - The date the employee was born.

**SOCIAL SECURITY NUMBER** - A number assigned by the Social Security Administration used to identify the employee.

**DATE HIRED** - The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

**STATE OF HIRE** - State where employee was hired.

**SEX** - The code which indicates the sex of the employee.

**MARITAL STATUS** - The code which indicates the marital status of the employee.

**OCCUPATION/JOB TITLE** - This is the primary occupation of the employee at the time of the accident or exposure.

**EMPLOYMENT STATUS** - Indicate the employee's work status. The valid choices are: Full-time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

**NCCI CLASS CODE** - A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

**RATE** - The reported employee's wage rate at the time of injury.

**# DAYS WORKED/ WEEK** - The number of days worked by the employee in a week.

**FULL PAY FOR DAY OF INJURY** - State whether employee was paid his full wages on the injury date.

**DID SALARY CONTINUE** - State whether employee's salary was continued by the employer in lieu of compensation benefits.

## OCCURRENCE/TREATMENT INFORMATION

**TIME EMPLOYEE BEGAN WORK** - The time employee began work on date of injury.

**DATE OF INJURY/ILLNESS** - The date employee was injured.

**TIME OF OCCURRENCE** - The time employee was injured.

**LAST WORK DATE** - The date employee last worked following the injury.

**DATE EMPLOYER NOTIFIED** - The date on which the employer was notified of the injury.

**DATE DISABILITY BEGAN** - The date on which employee began losing time.

**CONTACT NAME/PHONE NUMBER** - Name and phone number of employer representative to be contacted for further information.

**TYPE OF INJURY/ILLNESS** - Briefly describe the nature of the injury or illness, (e.g., Lacerations to the forearm).

**PART OF BODY AFFECTED** - Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

**DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES** - Mark yes or no as applicable.

**TYPE OF INJURY/ILLNESS CODE** - The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

**PART OF BODY AFFECTED CODE** - The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

**COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED** - The county where the injury occurred. If the injury did **not** occur in Mississippi, put "out of state".

**ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED** - List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint. Enter "NA" for not applicable if no equipment, materials, or chemicals were being used.

**SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED** - Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

**WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED** - Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

**HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL** - Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

**CAUSE OF INJURY CODE** - The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

**DATE RETURN(ED) TO WORK** - Enter the date following the most recent disability period on which the employee returned to work.

**IF FATAL, GIVE DATE OF DEATH** - Date of death of employee.

**WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEY USED** - Check applicable "yes" or "no" box.

**PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS)** - The name and address of the physician or health care professional providing initial treatment.

**HOSPITAL (NAME AND ADDRESS)** - The name and address of the hospital where employee was treated (if applicable).

**INITIAL TREATMENT** - Check applicable choices.

**WITNESSES (NAME & PHONE #)** - The name(s) and phone number(s) of any one who witnessed the accident.

**DATE ADMINISTRATOR NOTIFIED** - The date the carrier or claims administrator processing the claim received notice of the injury.

**DATE PREPARED** - The date this report was prepared.

**PREPARER'S NAME & TITLE** - The name and title of the person who prepared this report.

**PHONE NUMBER** - The phone number of the person who prepared this report.

Berkley Southeast Insurance Group
| a Berkley Company

# Claims Information Flyer

## Options to Report New Losses to Berkley Southeast Insurance Group (BSIG):

1. Contact your local agent
2. Phone us 24/7/365:
   - All losses except auto glass: 1(855) 802-5273
   - Auto glass-only losses: 1(800) 452-7449 *(and you can schedule your repairs today!)*
3. Report your loss on-line 24/7/365: REPORT LOSS ON-LINE LINK
4. Email us your loss info: newclaims@berkleysig.com
5. Fax us your loss info: 1(866) 814-7532

## All claims material (other than new loss notices) should be mailed to the following:

**All Workers Comp Medical Bills:**
BSIG/CareWorks
PO Box 1290
Canonsburg, PA 15317

**All other correspondence:**
Berkley Southeast Insurance Group
PO Box 5658
Meridian, MS 39302-5658
Email: claimsmail@berkleysig.com

## Claims Leadership Contacts:

| | | |
|---|---|---|
| Scott Jurek, VP Claims | sjurek@berkleysig.com | Phone: (678) 533-3407 |
| Christopher Calloway, WC Director | ccalloway@berkleysig.com | Phone: (678) 533-3418 |
| Steve Klayman , Auto Manager | sklayman@berkleysig.com | Phone: (678) 533-3424 |
| Jim Suppes, Quality & Ops. Director | jsuppes@berkleysig.com | Phone: (678) 533-3413 |
| Brian Philipovich, Major Case Unit Mgr | bphilipovich@berkleysig.com | Phone: (704) 759-7006 |
| Tyler Duggins, GL/Property Mgr. | tduggins@berkleysig.com | Phone: (678) 533-3447 |

## Site Links:

BSIG Claims Customer Page

Workers Compensation On-line Clams Info and Kits

*Your Back-In-Business Insurance Company™*

09/13/2018

Welcome to SmithRx. Your employer has chosen SmithRx to provide pharmacy benefits for their injured workers. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy.

Injured Employee:

- If you need a prescription filled for a work-related injury or illness, go to an in-network pharmacy. Provide this temporary card to the pharmacist. The pharmacist will fill your prescription at no cost to you.
- This card is valid for one-time use. You have 7 days from your date of injury to utilize this card.
- If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for future work-related injury or illness prescriptions.
- Most pharmacies, including all major chains, are included in this network. To find or inquire about a network pharmacy, call (844) 414-0701.

Questions?

- If you have any questions, please call (844) 414-0701 (also located on the back of your ID card).

**Employer:** ____________________

**First Name:** ____________ **Last Name:** ____________

**Social Security Number:** Please provide directly to Pharmacist

**Date of Injury:** ____________________

**Note to Cardholder:**
*Present this card to the pharmacy to receive medication for your work related injury*

**SmithRx is the designated PBM for this patient**

**Note to Pharmacists:**
*ENTER RxBIN, RxPCN, and GROUP*

*MEMBER ID # FORMAT IS DATE OF INJURY AND SSN COMBINED AS FOLLOWS*
*YYMMDD123456789*

*IF NO SSN, ALL 9s CAN BE USED*

Pharmacist Support
844-414-0703

| | |
|---|---|
| Rx Bin | 019025 |
| Rx PCN | 8001002 |
| Rx Group | BSIGFF |

Note: This First Fill card is only valid for your workers' compensation injury or illness

Berkley Southeast
Insurance Group
a Berkley Company

SmithRx
Pharmacy Benefits. Simplified.

## Bienvenido a SmithRx.

Su empleador nos ha elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales. Más adelante incluiremos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local.

## Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia en nuestra red. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica sin costo alguno.

Esta tarjeta es válida para un solo uso. Tiene 7 días a partir de la fecha de la lesión para utilizar esta tarjeta.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Puede utilizar esta tarjeta para futuras recetas médicas por lesiones o enfermedades relacionadas con el trabajo.

La mayoría de farmacias, incluyendo todas las grandes cadenas de farmacias, forman parte de nuestra red. Para encontrar una farmacia en nuestra red, llame al **(844) 414-0701**.

---

## ¿Tiene Preguntas?

Si tiene alguna pregunta, llame al **(844) 414-0701** (también se encuentra en la parte posterior de su tarjeta de identificación).

**Employer:** ______________________

**First Name:** ____________ **Last Name:** ____________

**Social Security Number:** Please provide directly to Pharmacist

**Date of Injury:** ______________________

**Note to Cardholder:**
*Present this card to the pharmacy to receive medication for your work related injury*

**SmithRx is the designated PBM for this patient**

Note to Pharmacists:
*ENTER RxBIN, RxPCN, and GROUP*

*MEMBER ID # FORMAT IS DATE OF INJURY AND SSN COMBINED AS FOLLOWS:*
*YYMMDD123456789*

*IF NO SSN, ALL 9s CAN BE USED*

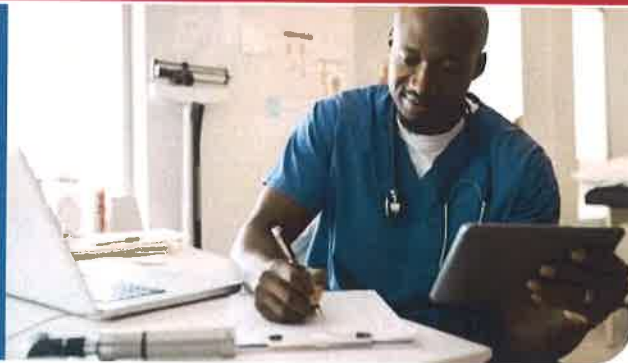
Pharmacist Support
844-414-0703

Rx Bin 019025
Rx PCN 8001002
Rx Group BSIGFF

Nota: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.

# Convenience. Compassion. Real Clinical Care

Bringing **convenience, compassion** and **real clinical care** to get injured employees **back-to-work** more quickly



## Berkley Southeast Insurance Group and Tele-Emergent Care

We understand the importance of responding quickly when an employee is injured on the job, whether the event requires emergency or non-emergency treatment.

**Our voluntary Tele-Emergent medicine care program for existing and new Workers' Compensation policyholders, provides injured employees immediate access to an emergency trained Physician in less than 5 minutes, without having to leave the work place.** Every workers' compensation event is triaged **by a highly trained physician Board Certified in Emergency Medicine**, who can advise, prescribe and refer, and is available 24/7/365 through our partnership with MedCall Healthcare Advisors, LLC.

### Benefits of our Tele-Emergent Care Program

**"Call a Doctor First"**

- Med-Call Advisors maintains the nation's largest Emergency Medical Practice
- Global 24/7/365 access via smart phone
- Real clinical care provided by Board Certified ER Physicians who make medical decisions that are in the best interest of the injured worker - potentially providing better outcomes
- Call Center staffed by medical professionals who document the event in real time
- Events accurately memorialized removing the burden of employers to recreate events
- Eliminates avoidable ER and Urgent Care visits
- Free Physician follow up for injured employee for up to 7 days
- Controls your medical costs potentially improving your E-mod
- Professional Registered Nurses follow up with employer and employee to assess future needs
- Assistance in early return to work when available, helps to improve overall workplace morale
- Bi-lingual Services available

*Of 6.5 million ER visits, 66% were classified as avoidable!*

*According to a Truven study. Source: United Healthcare Opinion Research

### Want to Know More?

**Contact your Territory Manager** or...

**Troy Landry** | VP Claims
tlandry@berkleysig.com

**Tracei Jackson** | WC Claims Director
trjackson@berkleysig.com

Your Back-in-Business Insurance Group℠

berkleysig.com

Acadia Insurance Company • Continental Western Insurance Company • Firemen's Insurance Company of Washington, D.C.
Tri-State Company of Minnesota • Union Insurance Company

**Notice:** For convenience, Berkley Southeast Insurance Group is providing to its policyholders access to MedCall for medical assistance/information, but Berkley Southeast Insurance Group does not endorse the use of MedCall or the information, products, or services (including, but not limited to, the appropriateness or suitability of any diagnosis, course of treatment or medical advice) provided by or accessible through MedCall. Access and use of MedCall, including the information, products, and services on or available through MedCall, is solely at your own risk, and Berkley Southeast Insurance Group makes no representations or warranties, express, statutory, or implied, with respect thereto. Berkley Southeast Insurance Group is not responsible or liable for any damage or loss caused, or alleged to be caused, directly or indirectly, under any theory of law, by or as a result of the use of or reliance on any information, products or services accessible from MedCall. BERKLEY SOUTHEAST INSURANCE GROUP IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, PRODUCTS OR SERVICES THAT YOU OBTAIN FROM MEDCALL.

Berkley Southeast Insurance Group is a member company of W. R. Berkley Corporation, a Fortune 500 Company, whose insurance company subsidiaries are rated A+ (Superior) by A.M. Best. Products and services are provided by one or more insurance company subsidiaries of W. R. Berkley Corporation. Not all products and services are available in every jurisdiction, and the precise coverage afforded by any insurer is subject to the actual terms and conditions of the policies as issued.

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04-2030