RECEIVED: _____
HORSEMEN'S WORKERS' COMPENSATION INSURANCE TRUST

OFFICE USE ONLY	**FARM ACCT #** _____
	Date _____
	NEW ( ) or RENEWAL ( )

"FARM" Application to Participate in the HORSEMEN'S WORKERS' COMPENSATION INSURANCE TRUST

Policy Period: July 1, 2022, to June 30, 2023

Owner Applicant Name *("Applicant")*						
Farm Name						
Business Structure	Individual ( )	Corporation ( )	Partnership ( )	LLC ( )	LLP ( )	Other:
Are you a first-time farm applicant? Yes ( ) No ( )						

Coverage is provided to employees of farm owners.

Farm Applicant Contact Info	Home Phone	Cell	Fax	Other
Applicant e-Mail			LSRC License #	

Applicant Address	**Street/P.O. Box**	**City**	**State**	**Zip**
Mailing				
Farm Physical Address *(if different)*				

Applicant Personal Info	SSN	TIN	DOB

Bookkeeper Name		Bookkeeper Email:		
Bookkeeper Phone	Office	Cell		
Bookkeeper Address	Street or P.O. Box:	City:	State:	Zip:
Mailing *(if different)*				
May we contact your bookkeeper directly during any audit of your account? *Yes ( ) No ( )*				

The Applicant named immediately above does hereby apply to the Horsemen's Workers' Compensation Insurance Trust (the "Trust"), a Trust organized under the laws of the State of Louisiana for Workers' Compensation and Employers' Liability indemnity protection to be **effective** at 12:01 a.m. on July 1, 2022, or on the date and time that this Application has been approved by the duly authorized representative of the Trust, whichever is later. If accepted by the Trust, Applicant does hereby constitute and appoint the Trust and/or the Administrator of the Trust as Applicant's Agent(s)-in-Fact for all matters relating to the Louisiana Workers' Compensation Law and/or any other Louisiana Laws which impose liability on an employer for damages sustained by an employee other than as may be imposed by the Louisiana Workers' Compensation Law.

Disclosure Statement

In addition to the terms and conditions contained in the **Trust Agreement**, as amended from time to time, and that certain **Indemnity Agreement** by which the Trust undertakes and agrees to defend and indemnify, subject to the terms and conditions therein, those Participants who have been accepted by the Trust for Workers' Compensation and **Employers' Liability Coverage** with respect to their Louisiana operations (the "Indemnity Agreement"), the Applicant does further agree and acknowledge as follows:

1. Applicant accepts and agrees to be bound by the provisions of the *Louisiana Workers' Compensation Act*;

2. That, by this reference, the terms and provisions of the Trust Agreement and/or any and all amendments thereto adopted, or which may hereafter be adopted by the Board of Trustees of the *Trust (copies of which will be provided to Applicant upon request),* are hereby adopted, approved, ratified and confirmed by Applicant;

3. Applicant does hereby assume and agree to be bound by all of the terms and conditions of: this Application, the Trust Agreement and any and all amendments thereto, the Indemnity Agreement issued to Applicant, and, if applicable, that certain Master Policy, which provides Coverage for Workers' Compensation and Employers' Liability in certain jurisdictions other than Louisiana (the "**Master Policy**");

4. Applicant agrees to pay all **costs of collection** of charges for Coverage, including reasonable attorney's fees, litigation expenses, and interest at a rate of twelve percent (12%) per annum from the date such charges were due, until paid;

5. Applicant hereby agrees to abide by the rules and regulations of the **Board of Trustees** of the Trust, and to conform to the terms of the agreement that they may enter into with any authorized service company;

6. In the event of any changes in Applicant's corporate or business structure, or in the event any locations are to be added or deleted from Applicant's business operations, Applicant shall notify the Trust, in writing, within 10 days of any such changes, additions or deletions;

7. The direct indemnity protection provided by the Trust shall be for Applicant's Louisiana operations only;

8. Applicant agrees to remain a member in **good standing** of the Louisiana Horsemen's Benevolent and Protective Association 1993, Inc. ("LAHBPA") for as long as Applicant's participation in the Trust continues;

9. Applicant agrees to promote, respond to, learn and comply with all **safety programs** adopted by the Trust, and understands that failure to do so may result in cancellation by the Trust of the Workers' Compensation and Employers' Liability indemnity protection afforded to Applicant by the Trust and, if applicable, the Master Policy. Applicant will require Applicant's employees to do likewise;

10. In the event Applicant desires to cancel or terminate its indemnity protection through the Trust and/or the Master Policy, Applicant does hereby agree to give written notice to the Trust at least thirty (30) days prior to the effective date of cancellation or termination;

11. The information set forth on the "LAHBPA Workers' Compensation **Farm Work List** attached hereto is true, correct and complete as of the date hereof. Applicant agrees to report any changes within 72 hours on the "Changes in your Employee Farm Work List form, a copy which is attached to this to this Application. **At no time, is any individual licensed as a jockey covered by this policy;**

12. Applicant has been offered/provided a copy or Applicant has received and read a copy of the document entitled, "**Instructions for Completing Application to Participate in The Horsemen's Workers' Compensation Insurance Program**" (Coverage Period 2022 – 2023);

13. All domicile determinations are subject to Trust approval;

14. Applicant hereby elects to apply to the Trust for **Farm Coverage**:

Please read and initial the box below regarding the Farm Insurance Coverage guidelines:

Farm Coverage
Applicant Initials here: _____
This Coverage is for quarter horse and thoroughbred farms which are located in Louisiana. This policy covers only "farm-related activities" on farms located in Louisiana, including activities involving a stallion, broodmare, nurse mare, teaser, foal, weanling or yearling. **(See Attachment B)** The cost for the Farm Coverage is 12% of audited farm payroll. There is a $1,000 **Minimum Annual Charge** for "Farm" Coverage. Farm payroll records MUST be submitted to LAHBPA at the end of the each of the following quarters, and are due **no later than 10 days after** each quarter listed below: Quarter 1: July 1, 2022, to September 30, 2022 *(payroll submission deadline: October 10, 2022)* Quarter 2: October 1, 2022, to December 31, 2022 *(payroll submission deadline: January 10, 2023)* Quarter 3: January 1, 2023, to March 31, 2023 *(payroll submission deadline: April 10, 2023)* Quarter 4: April 1, 2023, to June 30, 2023 *(payroll submission deadline: July 10, 2023)*
Farms that do not submit payroll records timely will be subject to probation, cancellation and/or non-renewal of their policy. Also, farms in arrears more than 30 days will receive a 10-day Cancellation Notice. Once a Cancellation Notice is issued for a Farm Policy, and that Farm brings the account current, the policy will not be canceled, but Probation Rates will apply.

FARM SALES COVERAGE PACKAGE

15. This Farm Sales Coverage package may be purchased only by Farms currently covered by a HWCIT Farm Policy, as the current Farm Policy does not cover sales. The Farm Sales coverage is good for one sale. Coverage is effective upon completion of the **Farm Sales Coverage Package** and the **Farms Sales Worklist**. *(See Attachment C and D.)*

16. The term of the agreement set forth here shall run concurrently with the term(s) of Coverage offered by the Trust, including any such Coverage certificates which are issued by the Trust to Applicant. The obligations of Applicant shall continue after the end of the policy period to the extent necessary for the Trust and the Trust's insurers to administer the affairs of the Workers' Compensation Insurance Program as those affairs relate to the Workers' Compensation Insurance Coverage provided to Applicant and to the extent necessary for Applicant to complete his obligations hereunder.

17. Applicant acknowledges that the following charges shall apply to policies in "**good standing:**"

"Farm" Coverage: The Minimum Annual Charge for "Farm" Coverage is $1000. Upon submission of your Application, YOU MUST PAY AT LEAST THE MINIMUM ANNUAL CHARGE, and within 15 days, you must pay any remainder of 25% of your Estimated Annual Premium. Your Estimated Annual Premium is calculated at 12% of your estimated annual farm payroll. Quarterly premiums are estimated at the start of each quarter based upon the most recent payroll submission provided. Premiums are regularly adjusted upon receipt of subsequent actual farm payroll submissions. Quarterly payments are invoiced and due 30 days after receipt of such invoice. Quarterly payments are to be paid to the Trust at LAHPBA's Main Office, at the start of each quarter, as outlined below:

1st Quarter *[July 1, 2022, to September 30, 2022]*
2nd Quarter *[October 1, 2022, to December 31, 2022]*
3rd Quarter *[January 1, 2023, to March 31, 2023]*
4th Quarter *[April 1, 2023, to June 30, 2023]*

As a requirement of this policy, you must provide the Trust with copies of your **quarterly farm payroll records,** whether you file with the appropriate taxing authorities or not. You must also update your payroll

submissions as reported to the Trust at least quarterly. Your payroll records will be audited at the end of each Coverage Period, and you will be required to pay any additional charges shown to be due. If additional charges are shown to be due following the audit, you may also be responsible for the cost of the audit.

18. See Attachment A, "**Farm Rate Guidelines,**" for policies not in good standing.

19. Upon request, Applicant will provide all **records or things** requested by the Trust which pertains to the Workers' Compensation Insurance Program including, but not limited to, payroll records, records or things pertaining to claims, safety, work lists, audits, and the number of farm employees employed by Applicant.

20. Applicant has accepted, posted and provided to each farm employee a copy of the **Substance Abuse Rule and Policy**, attached hereto and made part hereof, and will deliver a copy of said Substance Abuse Rule and Policy for each new farm employee. Applicant shall obtain a written receipt from each farm employee whereby the farm employee acknowledges receipt of a copy of the said Substance Abuse Rule and Policy.

21. Applicant has not made and will not make any omissions or misstatements of material fact to the Trust in the application process, in the claims process or otherwise.

22. Any person who knowingly and with intent to defraud the Trust or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties and will void any policy of insurance issued based upon the oral or written misrepresentation pursuant to ***LSA-R.S. 22:860***.

23. Immediately upon learning of any occurrence which could constitute a Workers' Compensation claim, Farm Applicant shall notify the Trust of such occurrence in writing and by placing a phone call to the Main Office, to **Vickie Lory or Mike Fenasci at 504-945-1555,** or to one of our Field Offices or to **Cindy Leigh**, Lead Field Manager at 337-660-8365. Applicant will not allow any individual who is not a farm employee of the Applicant and who does not perform services for the Applicant to file a claim for Workers' Compensation benefits using the name of the Applicant as his/her Employer. Should the Applicant be aware of such a fraudulent claim, and not notify the Trust, Applicant understands that the Trust has the right to void Workers' Compensation Coverage provided by the Trust and deny Workers' Compensation Coverage for any such claim.

24. Applicant hereby authorizes the Trust and its representatives to enter and inspect, during normal hours and under reasonable circumstances, any place where Applicant and/or Applicant's farm employees carry out work related to the Workers Compensation Insurance Program or where Coverage is provided or where records or other things relating in any way to the Workers' Compensation Insurance Program, or the Coverage provided are or were present. The entry authorized hereby shall be for the purpose of or related to the administration of the Workers' Compensation Program, including any claims made there under.

25. Should Applicant enter the Workers' Compensation Insurance Program at any time after July 1, 2022, the charges for any Coverage will NOT be prorated. There is a non-refundable **Minimum Annual Charge** (**$1,000** per Coverage Period), regardless of when the Coverage begins. All Coverage will expire on June 30, 2023, at midnight, regardless of when such Coverage began.

26. Applicant acknowledges that claims by injured farm employees, negative audit reviews, a failure to follow safety protocols, a failure to timely pay all charges when due, and/or other negative activity may result in increased percentage charges, non-renewal or cancellation of Applicant's coverage altogether.

27. Applicant acknowledges that an indexing inquiry may be obtained by the Trust from previous carrier(s) regarding past claims.

28. Applicant has read and hereby agrees to all of these terms, conditions, procedures, descriptions, disclosures, and explanations in the "**Instructions for Completing Application to Participate in The Horsemen's Workers' Insurance Compensation Program**" attached hereto and made part hereof.

29. Applicant acknowledges and agrees that the Trust has the **right to deduct any charges for Farm Coverage** from Applicant's Horsemen's Bookkeeper Account at any time should Applicant fail to pay any charges when due.

30. **Louisiana Law** shall apply to any and all disputes between the Trust and the Applicant which in any way arise out of: The Application, the Trust, the Indemnity Agreement, any Work List provided by Applicant to the Trust, the Workers' Compensation Insurance Program made available to Applicant through the Trust, or any claim for benefits.

31. Applicant acknowledges that participation in the Horsemen's Workers' Compensation Insurance Program and the Trust is a privilege, that Applicant has no inherent right to participate in the Horsemen's Workers' Compensation Insurance Program or the Trust, and that the Trust is the sole arbiter as to who may participate in the Horsemen's Workers' Compensation Insurance Program and the Trust. Applicant further acknowledges and agrees that the Trust may terminate this Agreement and may terminate Applicant's Workers' Compensation and employer's liability insurance Coverage, upon reasonable written notice to Applicant, for:

A. Any breach by Applicant of any of Applicant's obligations under this Application, the Trust, the Indemnity Agreement, or the Master Policy;
B. Applicant's failure to timely submit the required farm payroll records;
C. Applicant's failure to pay any charges when due;
D. Applicant's failure to remain a member in good standing of the LAHBPA; or
E. any other cause.

32. All **Farm Policy holders** are required to pay a non-refundable **$1,000** minimum payment or 25% of total estimated annual premium (12% of prior policy period payroll divided by 4), whichever is greater.

33. Further, if a farm during a policy period is in bad standing, that farm for the remainder of the policy period, will be placed on **probation.** (See *Attachment A* entitled, "**Farm Rate Guidelines**.")

Applicant Initials	

34. **Farm premiums** are based solely upon a percentage of farm payroll. Therefore, only paid farm employees are to be included on the Farm Work List to be covered by this policy. Any farm employee on the Farm Work List without current payroll information will not be covered and will be removed. It is your responsibility to update and maintain your Farm Work List at all times.

35. Applicant agrees that he/she has read the attached S**ubstance Abuse Rules and Policy** for the Horsemen's Workers' Compensation Insurance Program and Participating Employers, and he/she hereby agrees to observe and comply with said rule and policy.

36. Applicant further agrees that any and all **substance abuse rules and policies** heretofore acknowledged by Applicant as a condition to Applicant's applying for and obtaining Workers' Compensation Insurance Coverage through the LAHBPA with respect to prior coverage periods, shall also be enforceable by the Trust to the same extent as if the terms "Trustees of the Trust" or "Trust" were substituted wherever the term "LAHBPA" appeared in such other substance abuse rules and policies.

37. Attached hereto are **Receipts and Acknowledgements** signed by each farm employee who is listed on the Horsemen's Workers' Compensation Insurance **Farm Work List**. Applicant agrees that he/she will cause each farm employee hired after the date hereof to execute a Receipt and Acknowledgement whereby such farm employee acknowledges receipt of the Substance Abuse Rule and Policy promulgated by the Trust and that he/she will furnish such Receipts and Acknowledgements to the Trust promptly upon demand.

38. Applicant represents and warrants that all **Second Injury Fund Employee Questionnaires,** which are required to be attached to the Application, are, in fact, attached to the Application.

39. For each farm employee who is listed on the Horsemen's Workers' Compensation Insurance Farm Work List attached hereto, there is attached hereto is an executed **Medical Information Release** form, whereby the Trustees and/or Administrator of the Trust are authorized to request and obtain medical records. Applicant agrees that he/she will cause each farm employee hired after the date hereto to execute a Medical Information Release form, whereby the Trustees and Administrators representing the Trust are authorized to request and obtain medical records and will promptly provide such executed Medical Information Release forms.

40. Also, copies of the following materials are available for review at any LAHBPA Office. or you may view and/or download them online at **LAHBPA.ORG**: (1) Instructions for Completing the WC Farm Application; (2) Claims Reporting Protocol Book; (3) Safety Manual; and (4) the Indemnity Agreement.

41. The person signing this Application on behalf of Applicant certifies that he/she has the authority to execute this Application on behalf of the Applicant.

ACKNOWLEDGEMENTS

*Please read and initial each of the **Acknowledgements** below and **Section 33** on page 5*

Applicant Initials	Applicant Acknowledges:
	I acknowledge I have been offered/provided copies of the Claim Reporting Protocol Book and Instructions for Completing the Application, and I agree to the requirements and contents herein. *(Documents are available on the LAHBPA.org website).*
	I acknowledge I have been offered/provided a copy of this Application and informed I may contact any LAHBPA office at any time to request and receive an executed copy of my application.
	I acknowledge that it is the practice of the LHBPA to store contracts and other documentation electronically. I also acknowledge that the scanned or electronic version of this contract will be used in lieu of the originally signed hardcopy with my "wet" signature. Finally, all parties agree not to contest the use of the electronic version of this contract.
	I acknowledge that my farm premiums will be calculated at 12% of my annual farm payroll for all covered farm employees. *[Please refer to Farm Rate Guidelines, Attachment A.]*
	I acknowledge that if my farm is placed on probation, my premiums will be calculated at 15% of my annual farm payroll for all covered farm employees. *[Please refer to Farm Rate Guidelines, Attachment A.]*
	I acknowledge that I have read, understand and agree to the farm payroll submission requirements outlined herein.
	At no time is any individual licensed as a jockey covered by this policy.

Owner Applicant Name *Type or Print Name*	
Applicant Signature	**Date**

THE SECTION BELOW IS RESERVED FOR COMPLETION BY THE TRUST

This is to be completed by the FIELD OFFICE PERSONNEL who received the Application:

Name of LAHBPA Employee *Type or Print Name*	**Date**

This is to be completed by A Trustee, the Administrator or Field Rep, SPECIFICALLY DESIGNATED BY THE TRUST, before this policy becomes effective:

Application Accepted by Trust by *Type or Print Name*	
Signature	
Effective Coverage Date	

A Workers' Compensation Farm Insurance Certificate will be issued to Applicant upon request.

SELF-INSURANCE COVERAGE

Louisiana Law allows sole proprietors, partners and bonafide corporate executive officers, each owning not less than 10% of the stock therein to ACCEPT or REJECT Workers' Compensation coverage for himself/herself/themselves. Each sole proprietor, partner or such executive officer MUST sign for either REJECTION or ACCEPTANCE of this coverage below:

REJECTION

Sole-Proprietor Rejection

Name: _____ Title: _____

Signature: _____ Date: _____

Check one: ☐ **Partnership Rejection or** ☐ **Corporate Executives Rejection**

Name1: _____ Title: _____ % of Ownership _____

Signature: _____ Date: _____

Name2: _____ Title: _____ % of Ownership _____

Signature: _____ Date: _____

Name3: _____ Title: _____ % of Ownership _____

Signature: _____ Date: _____

Note: Your election to accept or reject Workers' Compensation Insurance Coverage will be effective on the inception date of coverage through the Fund and will remain in effect for the duration of the Member's participation in the Trust, unless rescinded, in writing, by the parties making the election.

ACCEPTANCE

If you accept this coverage, PLEASE CONTACT OUR OFFICE before submitting your application to discuss and submit your additional payment and payroll records.

The undersigned, does/do hereby agree to pay the additional $1000 **MINIMUM ANNUAL CHARGE** and the **ADDITIONAL PREMIUM** OF 12% of gross income in exchange for Workers' Compensation Self-Insurance Coverage through the Horsemen's Workers' Compensation Insurance Trust for the following individuals:

Sole-Proprietor Acceptance

Name: _____ Title: _____

Signature: _____ Date: _____

Check one: ☐ **Partnership Acceptance or** ☐ **Corporate Executives Acceptance**

Name1: _____ Title: _____ % of Ownership _____

Signature: _____ Date: _____

Name2: _____ Title: _____ % of Ownership _____

Signature: _____ Date: _____

Name3: _____ Title: _____ % of Ownership _____

Signature: _____ Date: _____

HORSEMEN'S WORKERS' COMPENSATION INSURANCE

FARM 2022-2023 WORK LIST

Add additional sheets, as needed.	*Worker's Compensation Classification & Code (Stables & Drivers Code # 8279).*

Email or drop off at the Main Office or any FIELD OFFICE Location in Louisiana.
Please list only your paid farm employees; unlisted employees may not be covered.
It is your responsibility to update and maintain your Farm Work List.

(Please refer to the requirements in #33 of the Farm Application.)

EMPLOYEE NAME	SSN	DOB	SEX M/F	POSITION	Weekly Pay	Estimated Q1 Wages (13 weeks)

A completed initial work list must accompany your WC Application. Unless a different estimation is provided, we will use this payroll information to compute your 1st Quarter estimated payroll and premium.

Owner/Applicant Name *Type or Print Name*	
Applicant Signature	**Date:**
***Farm Location**	

Please complete a separate form for each **farm location at which you have employees.*

HORSEMEN'S WORKER'S COMPENSTION INSURANCE TRUST

Changes to your Employee "Farm" 2022-2023 Work List

Add additional sheets, as needed.	*Worker's Compensation Classification & Code (Stables & Drivers Code # 8279).*

Email or drop off at the Main Office or any FIELD OFFICE Location in Louisiana.
Please list only your paid farm employees; unlisted employees may not be covered.
It is your responsibility to update and maintain your Farm Work List.

(Please refer to the requirements in #33 of the Farm Application.)

Applicant Name *Type or Print Name*	

"TERMINATED" EMPLOYEE NAME	**SSN**	**DOB**	**FULL or PART TIME**	**POSITION**	**WEEKLY HOURS AND PAY RATE**	**DATE TERMINATED**
"NEW" EMPLOYEE NAME	**SSN**	**DOB**	**FULL or PART TIME**	**POSITION**	**WEEKLY HOURS AND PAY RATE**	**DATE HIRED**

Owner/Applicant Signature		**Date**

Office Use Only:

EE # _____

LICENSE TYPE _____

DATE: _____

Horsemen's Workers' Compensation Insurance Program

Receipt and Acknowledgement of
Substance Abuse Rule and Policy by Employee

The undersigned employee hereby acknowledges receipt of the Substance Abuse Rule and Policy of Employer on the date this document was executed. Undersigned employee also agrees to be bound by the terms of that policy and to cooperate in the enforcement of same in order to help achieve a safer work environment.

Employee acknowledges that compliance with the Substance Rule and Policy of Employer is a condition of his/her employment and that among other things that Substance Rule and Policy of Employer prohibit the following:

> **Employees shall not introduce, manufacture, distribute, dispense, possess on employee's body or otherwise possess, use or consume alcoholic beverages, drugs, illegal drugs, and/or unauthorized prescribed drugs while in the course and scope of employment or in or upon the premises or property where employee is carrying out or normally carries out his/her employment duties. Violation of this Policy will be cause for disciplinary action, up to and including termination, in addition to any and all effects provided by law.**

Farm Employee Name *Type or Print Name*		**Date Hired:**
Farm Employee Signature *Guardian's signature if Employee is a Minor*		**Today's Date:**

Your Employment Info:	**Farm Name**	**Do you work Full-time or Part-Time?**	**Your Position?**	**Are you Male or Female:**

JOCKEY EXCLUSION:
I understand that at no time is any individual licensed as a jockey covered by this policy.

_____ _____
Employee Signature Date

SUBSTANCE ABUSE AND DRUG POLICY

PLEASE POST IN A CONSPICUOUS PLACE

This Substance Abuse and Drug Policy is a guideline to reduce substance abuse in the workplace. It may not prevent substance abuse from occurring. It does not address potential compliance issues with Federal, State or local OSHA or any other regulatory agency standards. Nor is it meant to be exhaustive or construed as legal advice. You should consult with your own legal counsel to address possible compliance requirements.

Scope

The Scope of this Policy is the establishment of a substance abuse rule and policy that will be adopted by all participating employers ("Employers") who have Coverage ("Coverage") pertaining to their employees in the Horsemen's Workers' Compensation Insurance Program ("Program") created and administered through the Horsemen's Workers' Compensation Insurance Trust ("Trust"), that is consistent with public policy and law, especially as provided in LA R.S. 23:1081. The Program is that Program implemented pursuant to LA R.S. 4:251 and 4:252.

Purpose

The purpose of these work rules is as follows:

- To establish and maintain a safe, healthy working environment for all employees;
- To reduce the possibility of accidental injury to persons or property.;
- To reduce absenteeism, tardiness, and indifferent job performance;
- To follow all applicable state, federal, and local requirements.

DEFINITIONS:

Alcohol or Alcoholic Beverage

Defined as any beverage that may be legally sold as alcohol. This includes, but is not limited to, fermented malt beverages, intoxicating liquor and wine.

Drug

Means any substance other than alcohol, which is capable of altering the mood, perception, pain level, or judgment of the individual consuming it, and which is recognized as a drug.

Illegal Drug

Means any drug or controlled substance, including prescription drugs, that is not used legally, any substance, whether it be narcotic or non-narcotic and those substances listed in Schedules I, II, III, IV and V of the Louisiana Revised Statutes.

Authorized Prescribed Drug

Means a drug prescribed by a licensed practitioner, and used in the manner, combination, and quantity prescribed, by the person for whom the drug is prescribed.

Prohibited Conduct

Employees shall not introduce, manufacture, distribute, dispense, possess in employee's body or otherwise possess, use or consume alcoholic beverages, drugs, illegal drugs, and unauthorized prescribed drugs while in the course and scope of employment or in or upon the premises or property where employee is carrying out or normally carries out his/her employment duties. Violation of this policy will be cause for disciplinary action, up to and including termination in addition to any and all effects provided by law. Reporting for work under the influence of an illegal drug, alcohol, drug, or unauthorized prescribed drug is cause for disciplinary action, up to and including termination. No prescription drugs shall be brought by employee or others upon the premises or property where employee is carrying out or normally carries out his/her employment duties except by the person for whom the drug is prescribed by a licensed practitioner. In such circumstance the prescribed drug shall be used solely in the manner, combination and quantity prescribed. When the use of drugs for medical purposes may affect behavior or performance, employees should advise their Employer that they are taking such drugs.

Employees are encouraged to voluntarily seek counseling from an Employee Assistance Program as needed, and the Trust and the Louisiana Horsemen's Benevolent and Protective Association 1993, Inc. ("LAHBPA") will field requests for referral to such programs.

Testing Circumstances: ***[Post-Accident]***
Employer or the Trustees of the Trust or designated representatives, on behalf of Employer, will conduct a drug and alcohol test whenever any employee is involved in a work-related accident as is provided by law, including as provided in LA R. S. 23:1081. All rights of Employer under LA R. S. 23:1081 are hereby reserved to Employer. Employer or the Trustees of the Trust or designated representatives, on behalf of Employer, will also conduct a drug and alcohol test whenever such is deemed prudent or necessary in providing a safe workplace and when the law so permits.

Refusal to Cooperate in Enforcing this Rule and Policy
Refusal of an Employer to cooperate fully in enforcing this Substance Abuse Rule and Policy will constitute grounds for the Trustees of the Trust to terminate Coverage afforded under any Workers' Compensation Insurance Certificate issued to Employer.

Specimen Collection and Collection Procedures
Specimen collection and testing will be conducted in a manner and under conditions which scientifically are generally accepted as being sufficient to reliably produce an accurate result. Any employee refusing to submit to a drug or alcohol test or leaving the Employer's premises or other work site without permission after being involved in a work-related accident will be subject to disciplinary action up to and including termination in addition to any and all effects provided by law.

Notification of Test Results and Record Keeping
The Trust, Employer and Employee shall be notified as soon as is practical of the results of the drug or alcohol test.

Severability
If any part or portion of this policy is held invalid by any court of competent jurisdiction or is otherwise determined to be invalid for any reason whatsoever, then, in that event, only that part or portion of this policy which is so held or determined to be invalid shall be invalid, and the remaining parts or portions shall remain in full force and effect.

Law Controls
If any part of this Substance Abuse and Drug and Policy conflicts with any law, including but not limited to LA R.S. 23:1081, the law shall prevail as it is not the purpose or intent of this law to waive any rights of Employer as set out in law.

ACKNOWLEDGEMENT OF SUBSTANCE ABUSE RULES & POLICY

Applicant Name *Type or Print Name*		
Applicant Signature		**Date**
LAHBPA Representative *Type or Print Name*		
LAHBPA Signature		**Date**

This substance abuse policy is a guideline to reduce substance abuse in the workplace. It may not prevent substance abuse from occurring. It does not address potential compliance issues with Federal, State, or local OSHA or any other regulatory agency standards, nor is it meant to be exhaustive or construed as legal advice. Consult your licensed commercial Property and Casualty representative at ***Safety National Insurance*** *or legal counsel to address possible compliance requirements.*

SECOND INJURY FUND EMPLOYEE QUESTIONNAIRE

Please answer the following questions by **circling** either **YES** or **NO:**

[Please use reverse side or separate paper if additional space is needed.]

1. Have you ever had a disease or disability from your occupation?	**YES**	**NO**
If YES, please explain:		

2. Have you ever received Workers' Compensation benefits for an injury that occurred at work?	**YES**	**NO**
If YES, when:		
How Long were you on compensation?		
Name of Employer:		
Nature of Injury:		

3. Have you ever been rejected for employment, insurance, or military service because of Health?	**YES**	**NO**
If YES, please explain:		

4. Have you ever had back trouble or an injury to your back, head, or neck?	**YES**	**NO**
If YES, please explain:		

5. Do you have any restrictions or limitations upon your physical activities?	**YES**	**NO**
If YES, please explain:		

6. What operations, accidents, broken bones, strains, or serious illnesses have you had?

7. Do you have any other long-term health problems or adverse physical conditions?	**YES**	**NO**
If YES, please explain:		

Warning: Pursuant to LSA-R.S. 23:1208.1, I understand that my failure to answer truthfully any of the above questions may result in denial or forfeiture of any right I or my dependents may have to workers' compensation benefits, including medical treatment and expenses.

I acknowledge I have read or have had the questionnaire read to me and understand this warning.

Employee Address	Home Address			Home City & State	Zip
Personal Info	Phone	Emergency Phone	DOB	SSN	LSRC#

Name *Type or Print Name*		
Signature *Guardian's signature if Employee is a Minor*		**Date**

Acknowledged by owners

MEDICAL INFORMATION RELEASE FORM

I, _____, authorize the Trustees or Administrator of the Horsemen's Workers Compensation Insurance Trust to request and obtain all records regarding any work-related or industrial accident in which I was involved or occupational disease which I have contracted.

This release is to include all doctor's reports, follow-up reports, nurses' notes, medical bills, test results, emergency room records, and all hospital records, etc. As well as visiting with the treating physician.

A facsimile or photo static copy of this executed release form shall be considered as effective and valid as the original. This release shall remain in effect unless and until specifically rescinded by me.

Employee Signature		**Date**

Must be completed before filing:

Is This Employee Full or Part Time?		**Farm Owner Signature**	**Today's Date**
Circle One:	Full Time Or Part Time		

FOR OFFICE USE ONLY

Must be completed before filing:

Reviewed by LAHBPA Employee *Type or Print Name*		**Date**

Office Use Only:

EMP # _____

LICENSE TYPE _____

DATE: _____

Programa de Seguro de Compensacion para Trabajador de Caballeros

Recibo de Reconocimiento de Abuso de Substancias-Póliza y Reglas del Empleado

El/ La empleado que firma consta que reconoce el recibo de la Póliza y Reglas de Abuso de Substancias del Empresario en la fecha que este documento fue firmado. El empleado también está de acuerdo de estar atado a los términos de esta póliza y a cooperar en hacer cumplir en la misma orden para así ayudar a lograr un área de trabajo seguro.

Los empleados reconocen que el cumplimiento de la Póliza y Reglas de Abuso de Substancias es una condición de su empleo además de otras cosas que la Póliza y Reglas de Substancias del empresario prohíbe como las siguientes:

> **Los empleados no deberán introducir, fabricar, distribuir, entregar, poseer, llevar consigo, usar o consumir bebidas alcohólicas, drogas, drogas ilegales, o medicamentos recetados por el médico no autorizados durante el curso y el alcance del empleo o en el local o propiedad donde los empleados normalmente llevan acabo sus obligaciones diarias. El violar esta póliza será causa para una sanción disciplinaria, y podría incluir hasta el despido, además de las consecuencias correspondientes con la ley.**

Nombre de empleado *Letra de Molde*		**Fecha De Contratacion**
Firma del empleado *Firma del Guardián si el Empleado es Menor*		**Fecha**

Su información de empleo	**¿Nombre de la granja?**	**¿Trabajas tiempo completo o medio tiempo?**	**¿Tu posición?**	**¿Es Usted hombre a mujer?**

JOCKEY EXCLUSION:
Entiendo que en ningún momento cualquier individuo tiene licencia como jinete cubierto por esta política.

_____ _____
Firma del empleado Fecha

Póliza y Reglas sobre el Abuso de Substancias Por la

Asociación Protectora y Benevolente de Caballerangos de Louisiana 1993, Inc.'s
Y Programa de Seguro e Indemnización al Trabajador y Empresarios Participantes

Alcance
El alcance de esta póliza es el establecimiento sobre la póliza y reglas del abuso de substancias las cuales pueden ser adoptadas por todos los empresarios participantes que tienen una cobertura relevante para sus empleados en la Asociación Protectora y Benevolente de Caballerangos de Louisiana 1993, Inc.'s y Programa de Seguro e Indemnización al Trabajador la cual es consistente con la ley y póliza publica especialmente proporcionada en los Estatutos Revisados de Louisiana 23:1081. El Programa es ese Programa implementado que prosigue bajo los Estatutos Revisados de Louisiana 4:252 y 252.

Propósito
El Propósito de estas reglas en el trabajo son las siguientes:

- El establecer y mantener un área de trabajo saludable y seguro para todos los empleados.
- El reducir la posibilidad de lesiones accidentales hacia personas y propiedades.
- El reducir el absentismo, tardío, rendimiento, e indiferencia al trabajo.
- El seguir todos los requisitos aplicables estatales, federales y locales.

DEFINICIONES

Alcohol o Bebidas Alcohólicas
Se refiere a cualquier bebida que puede ser vendida legalmente como alcohol. Esto incluye, pero no se limita, a bebidas malteadas fermentadas, vino y licor intoxicante.

Droga
Se refiere a cualquier sustancia (además del alcohol) la cual sea capaz de alterar el humor, percepción, nivel de dolor, o juicio de la persona consumiéndolo, y la cual sea reconocida como droga.

Droga Ilegal
Se refiere a cualquier droga o sustancia controlada, incluyendo medicamentos recetados por el medico, que no sean utilizados legalmente, ya sean narcóticos o no narcóticos, y todas la substancias en la lista en Schedules I, II, III, IV y V en los Estatutos Revisados de Louisiana.

Medicamento Autorizado
Se refiere a cualquier medicamento recetado por un practicante de medicina con licencia, el cual sea utilizado en el modo correcto. Debe de tener el tipo de combinación del medicamento, la cantidad recetada y el nombre de la persona utilizando el medicamento.

Conducta Prohibida
Los empleados no deberán introducir, fabricar, distribuir, entregar, poseer, llevar consigo, usar o consumir bebidas alcohólicas, drogas, drogas ilegales, o medicamentos recetados por el medico no autorizados durante el curso y el alcance del empleo o en el local o propiedad donde los empleados normalmente llevan acabo sus obligaciones diarias. El violar esta póliza será causa para una sanción disciplinaria, y podría incluir hasta el despido, además de las consecuencias correspondientes con la ley. Presentarse a trabajar bajo la influencia de una droga ilegal, alcohol, droga, o medicamento recetado no autorizado, será causa de una sanción disciplinaria, y podría incluir el despido. Los empleados no deberán llevar consigo ningún medicamento autorizado (que no les pertenezca) cerca de el local o propiedad donde los empleados llevan normalmente sus obligaciones diarias, excepto la persona para quienes realmente fueron recetados por un medico. La persona que esté utilizando medicamento recetado debe de usarlo solo conforme a la cantidad recetada y en la combinación correcta. Cuando el uso de este medicamento afecte el comportamiento o rendimiento en el trabajo los empleados deben informárselo a sus supervisores lo más pronto posible. Los empleados son animados a buscar voluntariamente cualquier tipo de conserjería conforme sea necesario de el Programa de Asistencia al Empleado y la Asociación Protectora y Benevolente de Caballerangos de Louisiana 1993, Inc.'s (HBPA) tendrá solicitudes para tales programas.

Razones para exámenes: Post- Accidente
Los empresarios o el HBPA, a nombre de los empresarios, conducirán un examen de alcohol y drogas siempre que un empleado tenga un accidente relacionado con el trabajo. Este examen será hecho conforme a las leyes y los Estatutos Revisados de Louisiana 23:1081. Todos los derechos del Empresario bajo los Estatutos Revisados de Louisiana 23: 1081 son reservados al Empresario. Los empresarios o el HBPA, a nombre de los empresarios, permitirán que nuestra compañía conduzca un examen de alcohol y drogas cuando ellos lo crean prudente o necesario para así poder proporcionar un lugar de trabajo sano y a salvo y cuando la ley lo permita.

Negarse a Cooperar y Cumplir esta Regla y Póliza
Si un empleado se niega a cooperar y cumplir la Póliza y Reglas del Abuso de Substancias el Programa de HBPA podría finalizar la Cobertura que este Programa provee para los empleados.

Colección de Muestras (espécimen) y Proceso de Colección
La colección de muestras y exámenes serán realizados bajo condiciones científicas, las cuales son generalmente aceptadas como resultados suficientes y fidedignas. El empleado que se niegue a someterse a un examen de alcohol y drogas o que se marche de la compañía, local o propiedad después de tener un incidente relacionado con su trabajo, podrá ser sujeto a una sanción disciplinaria o hasta el despido, además de todas las consecuencias correspondientes con la ley.

Confirmación sobre los exámenes
Si inicialmente un examen es positivo, será necesario hacer otra prueba para confirmar los resultados utilizando la muestra previa.

Notificación de Resultados de Exámenes y Registro
El HBPA, los Empresarios, y empleados deberán ser notificados lo mas pronto posible de los resultados de los exámenes de droga y alcohol. Nuestra compañía deberá notificar a su conductor o conductor aplicante de los resultados de los exámenes.

Privacidad
La privacidad de los empleados será mantenida como la ley lo requiere.

Amputaciones
Si alguna parte o porción de la Póliza es llevada por alguien a un cuerpo de autoridad o a una corte bajo una jurisdicción competente y es invalidada por cualquier razón, entonces solo la parte que sea invalidada lo será, y las secciones restantes que no sean invalidadas deberán continuar y proseguir en completa forma y efecto.

Controles de Ley
Si alguna sección de esta Póliza y Reglas de Abuso de Substancias es un conflicto con la ley, particularmente los Estatutos Revisados de Louisiana 23: 1081, la ley deberá prevalecer, ya que no es la intención de esta ley el no aplicar los derechos de los empleados.

Reconocimiento de normas y políticas de abuso de sustancias.

Nombre del solicitante *Escriba o imprima el*		
Firma del soliitante		**Fecha**
LAHBPA Representative *Type or Print Name*		
LAHBPA Employee		**Date**

Esta política de abuso de sustancias es una guía para reducir el abuso de sustancias en el lugar de trabajo. No puede evitar que se produzca abuso de sustancias. No se abordan posibles problemas de cumplimiento con las normas federales, estatales o locales de OSHA ni con ninguna otra norma de agencia reguladora. Tampoco se pretende que sea exhaustiva o interpretada como asesoramiento jurídico. Consulte a su representante comercial autorizado de Propiedad y Accidentes en ***Safety National Insurance*** *o asesor legal para tratar los posibles requisitos de cumplimiento.*

Segundo cuestionario del Empleado del Fondo de Lesión

Conteste por favor a las preguntas siguientes circundando cualquiera **Sí** o **No:**

[Utilice el reverso o papel separado si se necesita espacio adicional.]

1. ¿A tenido o tiene alguna enfermedad o discapacidad a causa de su trabajo?	**SI**	**NO**
Si **sí**, explique por favor:		

2. ¿A usted recibido beneficios de la compensación de trabajadores por alguna lesión ocurrido en el trabajo?	**SI**	**NO**
Si **sí**, cuando		
Cuanto tiempo estuvo en compensación		
Nombre del patrón:		
Naturaleza de lesión:		

3. H¿A usted sido rechazado para trabajo el seguro o servicio militar debido a su salud?	**SI**	**NO**
Si **sí**, explique por favor:		

4. ¿A tenido usted problemas en su espalda o alguna lesión en su espalda, cabeza o cuello?	**SI**	**NO**
Si sí, explique por favor:		

5. ¿Tiene usted alguna restricción o limitación sobre sus actividades físicas?	**SI**	**NO**
Si sí, explique por favor:		

6. ¿Qué operaciones, accidententes, huesos rotos, tensiones o enfermedades serias tiene usted?

7. ¿Tiene usted algún otro problema de salud a largo plazo o condiciones físicas adversas	**SI**	**NO**
Si sí, explique por favor:		

Advertencia: De conformidad con LSA-R.S. 23: 1208.1, entiendo que mi falta de respuesta con sinceridad a cualquiera de las preguntas anteriores puede resultar en la denegación o el decomiso de cualquier derecho que yo o mis dependientes puedan tener para los beneficios de compensación de trabajadores, incluido el tratamiento médico y los gastos.

Reconozco que he leído o he tenido el cuestionario leído a mí y entiendo la advertencia.

Dirección del empleado	La dirección			Ciudad local y estado	Código postal
Información personal	Teléfono	De emergencia	Fecha de nacimiento	El número de Seguro Social	# De Licencia LSRC

Nombre *Imprima*		
Su Firma *Firma de Guardian si el empleado es un menor*		**Fecha**

Acknowledged by Owners

FORMA MÉDICA DEL LANZAMIENTO DE LA INFORMACIÓN

yo, _____,autorizo él La. H.B.P.A. para solicitar y obtener todos los expedientes que miran y accidente de trabajo o enfermedad profesional que se implica y el La. H.B.P.A.

éste es incluir los informes del doctor, los informas de la carta recordativa, notas de las enfermeras las', las cuentas médicas, los resultados de la prueba el etc. Además de visitar con el médico tratante.

Una copia estática del facsímil o de esta autorización será considerada tan eficaz y válida como la original. Seguirá habiendo este lanzamiento en efecto hasta rescindido específicamente por mí.

Firma del empleado		**Fecha**

Is This Employee Full or Part Time?		**Farm Owner Signature**	**Today's Date**
Circle One:	Full Time Or Part Time		

FOR OFFICE USE ONLY (Solo para uso de oficina)

Must be completed before filing:

Reviewed by LAHBPA Employee: *Type or Print Name:*		**Date**

LOUISIANA HORSEMEN'S WORKERS' COMPENSATION INSURANCE TRUST

Carol Castille, Chairman

Kevin Delahoussaye, Trustee
Kenneth Lee Roberts, Sr., Trustee

Keith Hernandez, Trustee
Ron Faucheux, Trustee

Attachment A

Farm Rate Guidelines

Effective Date: 07-01-2022

Base Rate

The base rate is 12% of annual farm payroll. The first accident in a policy period will not count against a Farm's loss record for the policy period. A farm will remain in "good standing" and not subject to being placed on probation at a higher percentage of annual payroll, provided the farms loss ratio does not exceed **50%** of its annual payroll.

Each farm will be allowed one claim per policy period that does not count against its frequency rate, and an additional claim for every (5) five active employees on the farm's current Work List. Employees must be current, and actively working to be counted against the farm's claim frequency rate. If a farm's claim frequency rate exceeds the maximum allowed and has a loss ratio of more than 50% of payroll, that farm will be subject to being placed on probation *(see "Probation Rate" below).*

Probation Rate

If a farm is placed on probation during a policy period, its rate shall be increased to fifteen percent **(15%)** of annual payroll for the remainder of the policy period and for the next proceeding policy.

All decisions of the Louisiana Horsemen's Workers' Compensation Insurance Trust shall be done pursuant to a meeting called by the HWCIT Chairman in which at least **60%** of the Trustees participate, *[either in person or by phone]*, and a majority vote of the members present is obtained on each decision. The decision is final and non-appealable.

FARM INSURANCE COVERAGE ACTIVITIES

"Farm" coverage is for quarter horse and thoroughbred farms located in Louisiana and not engaged in racing or training activities. This Farm Policy covers all farm-related activities on farms located in Louisiana, including activities involving a stallion, broodmare, nurse mare, teaser, foal, weanling or yearling.

If an employee, at the time of an incident, is working with a brood mare, weanling, yearling, teaser or other horse associated with a breeder farm, that employee would be covered by the Farm Policy. On the other hand, if at the time of an incident, an employee is galloping a horse, the employee would be covered under the Trainer Policy. Some employees work as "dual" employees, working at both farm-related activities and racing and/or training activities. The activity which the employee is performing at the time of an incident will determine whether the employee is covered under the Farm Policy or the Trainer Policy.

If you are engaged in any of these farm-related activities and are also engaged in racing and/or training activities, you should consider purchasing "Farm" coverage **IN ADDTION TO** the "All States" coverage or the "Louisiana Only" coverage, as listed on the Trainer Application.

The cost for the "Farm" coverage is 12% of the audited annual farm payroll. There is a $1,000 Minimum Annual Charge for "Farm" coverage. If "Farm" coverage is purchased in conjunction with the purchase of either "All States" or "Louisiana Only" coverage, the Minimum Annual Charge for "Farm" coverage is an additional $1000.

The selection of the "Training" coverage is final for the policy year selected and no change will be allowed. **The "Training" coverage will not cover any employee injured in connection with any activity involving a stallion, brood mare, nurse mare, teaser, foal, weanling or yearling. These activities, which are excluded from "Training" coverage, will only be covered under "Farm" coverage,** which may be obtained from LAHBPA or by a Farm Policy obtained from a third party.

LOUISIANA HORSEMEN'S WORKERS' COMPENSATION INSURANCE TRUST

Carol Castille, Chairman

Kevin Delahoussaye, Trustee
Kenneth Lee Roberts, Sr., Trustee

Keith Hernandez, Trustee
Ron Faucheux, Trustee

Attachment C

Farm Sales Coverage Package

Policy Year: 2022-2023

This Farm Sales Coverage may be purchased only by Farms currently covered by a HWCIT farm policy, as the current Farm Policy does not cover sales. This coverage is good for one sale.

This insurance coverage terms provide as follows:

1. Coverage shall be effective upon of the "Effective Date" indicated below;
2. The policy coverage is for a maximum of 30 days;
3. The policy is issued for one thoroughbred or quarter horse sale;
4. All employees covered under this policy must be hired in Louisiana;
5. "Existing or current" farm employees of record, with at least 60 days employment prior to submitting this Farm Sales Application, will be covered by your existing Farm policy;
6. Farms not on probation at the time of this application, will not be charged the $250 "Farm Sales" premium for those "existing" employees attending the sale;
7. The Farm Sales premium for "freelance" employees is $250 per freelance employee attending the sale,
8. Farms on probation at the time of this Application, will be charged the $250 "Farm Sales" premium for each employee, whether "existing" or "freelance", attending the sale;
9. This separate policy addendum *(Attachment C)* must be completed for each sale;
10. This policy is allowed only in the non-restricted states*; and
11. This policy will cover only employees listed on the attached Farm Sales Work List *(Attachment D)* whether an "existing or current" employee or a "freelance" employee.

**Restricted States: NY, CA, OH, ND, and WA*

Date of Sale		**Location of Sale**	
Policy Effective Date		**Policy End Date** *(30-day max)*	

Applicant Name	
Applicant Signature	
Signature Date	

HORSEMEN'S WORKERS' COMPENSATION

Policy Year: 2022-2023

Attachment D

"Farm Sales" Work List

Add additional sheets as needed.	*Worker's Compensation Classification & Code (Stables & Drivers Code # 8279).*

Please list only your employees to be covered for this one sale; unlisted employees may not be covered. It is your responsibility to update and maintain your Farm Work List.

Employee Name	Existing or Freelance EE	SSN	DOB	Sex M/F	Position	Freelance EE Premium Rate
						$250.00
						$250.00
						$250.00
						$250.00
						$250.00
						$250.00

Owner/Applicant Name: *Type or Print Name*	
Applicant Signature:	
Farm Sale Location and date: *	

Please complete a separate form for each **farm sale for which you have employees.*