

Workers' Compensation



OSCPA Workers' Compensation Insurance Program

No Expense Constant

The expense constant is automatically waived under the Oklahoma Society of CPA's Workers' Compensation policy--that's \$140 savings to you!

Special Rate Modifier

We use the rates approved by CompSource Oklahoma for your applicable remuneration code.

In addition, the OSCPAs policy is given a special rate modifier based on the entire group's claims experience. Since 1995, this discount has ranged from 18%-32%.

No Medical Deductible

The policy contains no medical deductible.

Increased Employer Limits of Liability

This policy provides increased Employers Liability Limits at no additional cost to you.

These limits are:

Bodily Injury by Accident \$500,000 each accident

Bodily Injury by Disease \$500,000 policy limit

Bodily Injury by Disease \$500,000 each employee

Reduced Minimum Premium

The OSCPAs Workers' Compensation policy has a minimum premium of \$135-\$158. That's a 25% savings off CompSource Oklahoma's minimum premiums!

Simplified Paperwork

To enroll, simply complete and return the enclosed application and enrollment form. Upon receipt and acceptance, we will calculate your premium and send your bill. Renewal is even easier -- completion of a short renewal form is all that is required.

How do I join the OSCPAs Workers' Compensation policy?

You are invited to participate in the Oklahoma Society of CPA's Workers' Compensation Insurance Plan. Nearly 300 firms are enrolled in the plan and take advantage of the savings in time and money.

You will be participating under a Master Policy issued by CompSource Oklahoma to the Oklahoma Society of Certified Public Accountants. Richard A. Beale of Beale Professional Services will administer the program under authority of Power of Attorney conveyed by the OSCPAs (copy enclosed). Please note that, for the OSCPAs plan, neither Richard A. Beale, nor any of his employees, represent or act as agents of CompSource Oklahoma.

The Master Policy issued to the OSCPAs will have an annual anniversary date of November 1. However, you may join the OSCPAs policy at any time. If your present coverage expires on a date other than November 1, your coverage and premium will be prorated. Please keep in mind that your application must be received and approved, and premium received prior to coverage becoming effective.

To receive a no-obligation premium proposal, please call or fax us your current payroll information. To enroll, simply complete and return the enclosed application and enrollment form. Send no money now, we will notify you of premium due.



**Professional
Services**

**PO Box 60809
Oklahoma City, OK
73146**

**4201 N. Barnes Avenue
Oklahoma City, OK
73112**

**www.bealepro.com
beale@bealepro.com**

(405) 521-1600

Fax: (405) 521-1610

Toll-Free (800)530-4863

Rev.10/04

POWER OF ATTORNEY

KNOW ALL MEN OF THESE PRESENTS:

THAT Oklahoma Society of Certified Public Accountants, a corporation, has made,
(POLICYHOLDER COMPANY NAME)
constituted, appointed and by these presents does make, constitute, and appoint Richard A. Beale
(INDIVIDUAL'S NAME)
of Beale Professional Services our true and lawful attorney for us and in our name, place,
(AGENCY/COMPANY NAME)

and stead, to execute and deliver any and all instruments, forms, or documents, and to do any act that may be required by CompSource Oklahoma in order to obtain workers compensation insurance; to receive any and all documents, forms, bills, invoices, and other instruments that may be sent by CompSource Oklahoma with regard to workers compensation insurance; to request and receive from CompSource Oklahoma any and all documents, forms, bills, invoices, and other instruments that may be deemed necessary by our attorney; to deliver to CompSource Oklahoma any and all documents, forms, and other instruments; and to make disbursements to CompSource Oklahoma of such moneys as may be necessary to keep workers compensation insurance in full force and effect; to do any act necessary to process workers compensation insurance claims in cooperation with CompSource Oklahoma; hereby giving and granting unto our said attorney full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done with CompSource Oklahoma to obtain and keep the workers compensation insurance in full force and effect, and to process claims against such insurance, as fully to all intents and purposes as we might or could do if personally present, with full power of subscription and revocation, hereby ratifying and confirming all that our said attorney may do. This Power of Attorney shall remain in full force and effect unless and until the undersigned notifies CompSource Oklahoma in writing of its revocation.

Executed this 3rd day of November, 2004

Daryl Hill
Corporate Officer
Executive Director
Title

STATE OF Oklahoma
COUNTY OF Oklahoma

Before me, the undersigned authority, within and for said County and State, and on this 3rd day of November, 20 04, personally appeared Daryl J. Hill, to me known to be the Executive Director of Oklahoma Society of CPAs, a corporation, and acknowledged to me that he/she executed the same as his/her free and voluntary act and deed and as the free and voluntary act and deed of said corporation for the uses and purposes therein set forth.



Annie Dilbeck
Notary Public
My Commission Expires July 29, 2006
Commission Number 02011436



Application for Workers' Compensation

Underwritten by CompSource Oklahoma

Section 1 Applicant Information

Firm Name: _____ Contact Person: _____

Address: _____ City, State, Zip: _____

Additional Locations: _____

Phone #: _____ Fax #: _____ E-mail: _____

Business Entity: _____ Federal ID #: _____ OSCPA #: _____

(Sole Proprietor, S-corp, C-corp, Partnership, LLC, etc.)

Do you have any subsidiaries or ownership interest in other business entities, or are you a subsidiary of another entity? Yes No **If yes**, please list all other entities on a separate page and whether covered under separate Workers' Compensation policy.

(Application must be approved and premium received before effective.)

Section 2 Policy Information

Desired Coverage Effective Date: _____

Have you had Workers' Compensation Insurance in the past 12 months? Yes No *If no, skip to Section 3.*

If yes, list: Previous Insurer: _____ Policy #: _____ Expiration Date: _____

Have you had any Workers' Compensation losses during the past three years? Yes No *(If Yes, please attach a 3-year Loss Run)*

Section 3 Rating Information

3a) Owner-Employees: LLC Members, Partners, Sole Proprietors, and Stockholder Employees owning 10% or more of the company stock are automatically excluded from coverage. If coverage is desired for these persons, it must be elected in this section.

Please list **all** Corporate Officers, LLC Members, Partners, Sole Proprietors and Stockholder Employees here (attach an additional sheet, if necessary). Please indicate whether LLC Members, Partners, Sole Proprietors or 10% or more Stockholder Employees are to be covered. Non-owner corporate officers or corporate officers owning less than 10% of the company stock must be covered.

Refer to the reverse side of this page for remuneration minimums, maximums and guidelines.

	Name	Duties / Office	% Ownership	SSN	8803 Remuneration	8810 Remuneration	Covered? (Circle)	
1							Yes	No
2							Yes	No
3							Yes	No
4							Yes	No
5							Yes	No

3b) All non-Owner Employees and Corporate Officers: Names are not necessary in this section. Please include Remuneration for all non-Owner Employees and Officers.

Class Code	Duties	No. Of Employees	Estimated Annual Remuneration
8803	See Definition on Reverse		
8810	See Definition on Reverse		

Section 4 Totals: - Please provide total covered remuneration for owners and non-owners, from 3a and 3b.

Class Code	Duties	No. Of Persons	Estimated Annual Remuneration
8803	See Definition on Reverse		
8810	See Definition on Reverse		

Signature of Owner/Officer

Title

Date



PO Box 60809
Oklahoma City, OK 73146

(405) 521-1600 OKC (800) 530-4863
(405) 521-1610 FAX

OSCPA WC 10/04

CLASS CODE 8803: AUDITORS OR ACCOUNTANTS – TRAVELING

Code 8803 is applicable to traveling clerical-type employees of risks engaged in the business of providing accounting, auditing, office systemization, computer programming or related clerical services for their clients. *Employees assigned to Code 8803 will be performing clerical work when they arrive at a client's location.*

CLASS CODE 8810: CLERICAL OFFICE EMPLOYEES N.O.C

Since Accountants and their office employees are not specifically classified elsewhere, Code 8810 Clerical Office Employees Not Otherwise Classified has been assigned. This classification includes those employees who are primarily engaged in bookkeeping, record keeping, drafting or other office works where books and records are kept or correspondence is conducted. *Please Note:* Incidental travel that is directly related to an employee's office duties (such as depositing funds at the bank, purchasing office supplies, pickup or delivery of mail) is included in 8810.

REMUNERATION means money or money substitutes and includes payroll, salaries, wages, commissions, bonuses, extra wages for all overtime work (i.e. straight time) wages of holiday, vacations, sick periods, meals, lodging and payment to the employees made on the basis other than that of time actually engaged in work, including but not limited to piece work, incentive plans, or profit sharing arrangements.

Title 85 of Oklahoma State Statues declares that stockholder employees owning 10% or more of the corporate stock, sole proprietors, LLC members, or partners of a business are not covered under Workers' Compensation but may elect coverage subject to the below remuneration minimums and maximums:

Minimum/Maximum Remuneration:

TITLE	MINIMUM		MAXIMUM
Corporate Officers, use:	\$13,000	-	\$109,200
If both Corporate Officer and Stockholder Employee , use:	\$13,000	-	\$109,200
Sole Proprietors, Partners & LLC Members , use	\$26,800	-	\$26,800
Stockholder Employees , use:	Actual Remuneration – No Min/Max		
Other Employees , use:	Actual Remuneration – No Min/Max		

POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

Coverage for acts of terrorism is already included in your current policy. You should know that, effective November 26, 2002, under your existing coverage, any losses caused by certified acts of terrorism would be partially reimbursed by the United States under a formula established by federal law. Under this formula, the United States pays 90% of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The portion of your annual premium that is attributable to coverage for acts of terrorism is: \$0.

ENROLLMENT FORM

OKLAHOMA SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS (OSCPA) COVERAGE PROVIDED BY COMPSOURCE OKLAHOMA (CSO)

BUSINESS NAME

STREET ADDRESS

CITY

ZIP

As a member in good standing of the OSCP, the above business hereby applies for enrollment as a participating member in the OSCP Workers' Compensation policy.

It is understood and agreed as follows:

- (1) That the application must be approved by CSO as well as the OSCP and the premium paid in advance before coverage becomes effective. Failure to pay premiums when due will result in the termination of the insured entity by the OSCP and CSO. The OSCP will not be responsible for payment of premium for any member or member firm.
- (2) Safety refunds/dividends, if any, will be paid to and retained by the OSCP to be used at the discretion of its Board of Directors.
- (3) Title 85 of the Oklahoma Statutes states that stockholder employees owning 10% or more of the corporate stock, owners, or partners of this business are not covered under this policy but can elect coverage subject to the respective minimums and maximums as prescribed by the Manual Rules of CSO by so declaring on the prescribed form.
- (4) CSO retains the right to conduct an audit of all your books and records needed to compute premium, either on-site or by requesting information through the mail.
- (5) The member grants Power of Attorney to Richard A. Beale according to the terms and conditions of the sample Power of Attorney form attached.
- (6) NOTE THAT NEITHER RICHARD A. BEALE NOR ANY OF HIS EMPLOYEES REPRESENT OR ARE AN AGENT OF CSO.

Evidence of insurance will be furnished to the member by CSO upon compliance of the member with the pertinent terms and conditions of participation as outlined herein.

AUTHORIZED SIGNATURE

TITLE

DATE

OKLAHOMA ELECTION OF COVERAGE

Sole proprietors, members of a partnership, members of a limited liability company who own at least 10% of the capital of the limited liability company, or any stockholder-employees who own 10% or more stock in the corporation are specifically **excluded** from the definition of "Employee", and **shall not be deemed to be employees** as respects the benefits of the Workers' Compensation Act.

You have the **option to elect to include**, as applicable, your sole proprietor, any or all of your partnership members, any or all of your limited liability company members who own at least 10% of the capital of the limited liability company, or any or all of your stockholder-employees who own 10% or more stock in the corporation, **as employees** by endorsement to the policy in accordance with Section 3 of Title 85 of the Oklahoma Statutes.

The premium for the sole proprietor, partnership members, and limited liability members, who are eligible for election, shall be based on the fixed amount of payroll according to the "Miscellaneous Values" effective on your Anniversary Rating Date. The premium for the stockholder-employees, who are eligible for election, shall be based on no less than the minimum remuneration limitation according to the "Miscellaneous Values" effective on your Anniversary Rating Date, up to the maximum remuneration or their actual remuneration, which ever is greater.

INSTRUCTIONS: Each individual eligible for election of coverage must provide their signature on this form. Please sign, either: Item I if you do not desire coverage, or Item II if you do desire coverage.

Date: _____ Application or Policy No. _____

Business Type (check one): Limited Liability Company Sole Proprietor Partnership Corporation

IMPORTANT: You must notify CompSource Oklahoma whenever your ownership changes. Coverage will be endorsed and effective the date we receive this completed form in our office.

ITEM I - I am eligible for election of coverage, and understand that I am excluded from the definition of employee, and shall not be covered under the workers' compensation policy issued by CompSource Oklahoma. I state under penalty of perjury under the laws of Oklahoma that the representation of ownership on this election of coverage is true and correct.

<i>NAME</i>	<i>SIGNATURE</i>	<i>% OF OWNERSHIP</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ITEM II - I am eligible for election of coverage, and I elect to be covered under the workers' compensation policy issued by CompSource Oklahoma. I state under penalty of perjury under the laws of Oklahoma that the representation of ownership on this election of coverage is true and correct.

<i>NAME</i>	<i>SIGNATURE</i>	<i>% OF OWNERSHIP</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____