

# CANAL INSURANCE COMPANY

## OFFER OF OPTIONAL DEDUCTIBLES FOR CLAIMS BENEFITS PAYABLE

Insured: \_\_\_\_\_

Policy #: \_\_\_\_\_  
TO BE COMPLETED BY COMPANY

Effective Date: \_\_\_\_\_  
TO BE COMPLETED BY COMPANY

The Insured may choose a deductible to help reduce the Insured's premium and future experience modifications, if applicable. The Insured is not required to participate in this deductible program. This signed form will become a part of the Insured's permanent file.

When an Insured chooses a deductible, the Company will administer and pay all claims. The Insured will reimburse the Company for payments made within the amount of the deductible selected.

Workers' Compensation coverage applies to benefits only in excess of the deductible chosen below. The deductible applies separately to each bodily injury by accident or disease, including allocated loss adjustment expenses.

The Company will pay the deductible amount to the claimant or provider of services, but the Insured must reimburse the Company within 30 days after the Company mails notice that the payment is due. The reimbursement of the deductible amounts to the Company shall be treated in the same manner as payment or non-payment of premiums. If the Insured fails to reimburse the Company, the Company may terminate Insured's coverage in the Company per the Cancellation Section of the policy. The Company may keep the amount of unearned premium that will reimburse it for the claimant or provider payments made. These rights in addition to other rights the Company has to be reimbursed.

The following are the deductibles and corresponding premium reductions available to you.

<u>Deductible Amount</u>	<u>Premium Reduction</u>
\$500	4.5%
\$1,000	6.8%
\$1,500	8.5%
\$2,000	9.9%
\$2,500	11.0%
Other	Subject to Company

Please initial below and insert the amount of deductible to be applied. You may change your deductible on the next anniversary.

Yes, I accept a deductible of \_\_\_\_\_ applied to each compensable claim under the policy. I understand that the Company shall pay the deductible amount and be reimbursed by the Insured shown above.

No, I do not want to participate in the deductible program.

\_\_\_\_\_  
Signed by:

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date