# ASSOCIATION OF COUNTY COMMISSIONS OF ALABAMA
LIABILITY SELF-INSURANCE FUND, INC.
LIABILITY COVERAGE DECLARATIONS

Named Covered Person: Houston County Commission
Participation Agreement #: 0040-0035

**Liability Coverage Period:**

| Effective Date: | January 1, 2019 | Expiration Date: | January 1, 2020 |

At 12:01 a.m. Standard Time at the address of the Named Covered Person

Retroactive Date for Parts I-VI & VII N/A
Retroactive Date for Part VII: January 1, 2015

See Liability Coverage Document for explanation of Retroactive Coverage Period.

## LIMITS OF COVERAGE

<table>
<thead>
<tr>
<th>Type of Coverage</th>
<th>Limit (in USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL ANNUAL AGGREGATE LIMIT</strong></td>
<td>$3,000,000</td>
</tr>
<tr>
<td><strong>PART I - GENERAL LIABILITY COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>Each Occurrence or Offense Limit *</td>
<td></td>
</tr>
<tr>
<td>Deductible for Any One Claim +</td>
<td>$1,000,000</td>
</tr>
<tr>
<td><strong>PART II - AUTOMOBILE LIABILITY COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>Each Accident Limit *</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Deductible for Any One Claim +</td>
<td>No Deductible</td>
</tr>
<tr>
<td><strong>PART III - LAW ENFORCEMENT LIABILITY COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>Each Occurrence Limit *</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Deductible for Any One Claim</td>
<td>No Deductible</td>
</tr>
<tr>
<td><strong>PART IV - ERRORS AND OMISSIONS LIABILITY COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>Each Error or Omission Limit *</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Deductible for Any One Claim</td>
<td>No Deductible</td>
</tr>
<tr>
<td><strong>PART V - EMPLOYMENT PRACTICES LIABILITY COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>Each Employment-Related Practice Limit *</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Deductible (for Loss Only) for Any One Claim</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>PART VI - EMPLOYEE BENEFITS ADMINISTRATION LIABILITY COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>Each Error or Omission Limit *</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Deductible for Any One Claim</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>PART VII - PRIVACY OR SECURITY EVENT LIABILITY AND EXPENSE COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>Separate General Aggregate for this Coverage Part</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Deductible for Any One Claim</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>PART VIII - EQUITABLE DEFENSE COVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>Each Defense Expense Limit</td>
<td>$225,000</td>
</tr>
<tr>
<td>Deductible (for Defense Expenses) for Any One Claim</td>
<td>No Deductible</td>
</tr>
</tbody>
</table>

* Unless reduced by any applicable statutory or legal limit or immunity (e.g., Alabama Code, § 11-93-2: Recovery of damages against governmental entity limited to $100,000 bodily injury or death each person, $300,000 each occurrence, and $100,000 property damage each occurrence). Defense expenses are included within and reduce the Limits of Coverage. Each limit is subject to the General Annual Aggregate Limit. Coverages may not be combined for any claims.

+ If "No Deductible" is stated, there will be a $100.00 deductible for Glass Breakage.
ASSOCIATION OF COUNTY COMMISSIONS OF ALABAMA
LIABILITY SELF-INSURANCE FUND, INC.
LIABILITY COVERAGE

Named Covered Person: Houston County Commission  Participation Agreement #: 0040-0035

FORMS AND ENDORSEMENTS CONTAINED IN THE COVERAGE DOCUMENT AT ITS INCEPTION:

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>18A</td>
<td>Professional Health Care Services</td>
</tr>
<tr>
<td>93</td>
<td>Equitable Defense - Tax Appeal</td>
</tr>
<tr>
<td>95</td>
<td>Unmanned Aircraft</td>
</tr>
</tbody>
</table>

ANNUAL CONTRIBUTION (Including endorsement costs): $354,887.00

These Declarations, together with the Participation Agreement and the Liability Coverage Document and Endorsements, if any, issued to form a part thereof, complete the coverage afforded by participation in the ACCA Liability Self-Insurance Fund. See Coverage Document for definitions of occurrence, offense, accident, error or omission, employment-related practice, cyber security event and defense expenses.

(Member Representative - Signature)  (Member Representative - Title)  (Date)

(Fund Administrator)  January 1, 2019  (Date)
HOUSTON COUNTY ACCIDENT / INCIDENT REPORT
PRELIMINARY INVESTIGATION

BACKGROUND INFORMATION:

<table>
<thead>
<tr>
<th>Accident/Incident Occurred:</th>
<th>Date:</th>
<th>Time:</th>
<th>Day of the Week Accident Happened:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident /Incident Reported:</td>
<td>Date:</td>
<td>Time:</td>
<td>(M) (T) (W) (T)</td>
</tr>
<tr>
<td>Accident/Incident Investigation Began:</td>
<td>Date:</td>
<td>Time:</td>
<td>(F) (Sa) (S)</td>
</tr>
</tbody>
</table>

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EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>Name (Last, First, Mi)</th>
<th>Job Title at time of Injury / Illness:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address:</td>
<td># Years in Job Position:</td>
</tr>
<tr>
<td>Supv. at Time of Injury / Illness:</td>
<td></td>
</tr>
<tr>
<td>Location at time of Injury/Illness:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone #:</th>
<th>Witness(es):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
</tbody>
</table>

NON-EMPLOYEE INFORMATION (CLAIMANT) Fill out if another party was involved in the Accident / Incident

<table>
<thead>
<tr>
<th>Claimant Name (Last, First, Mi)</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Number:</td>
<td></td>
</tr>
</tbody>
</table>

ACCIDENT / INCIDENT LEVEL

A. No Injury
   __ At Risk Behavior
   __ Near Miss
   __ Property Damage

B. Injury
   __ Record Only
   __ First Aid by Employer
   __ Medical Treatment
   __ Lost Time
   __ Fatality
   __ Other

Description of Injury or Illness, Part of Body Affected and Treatment Received: (Check if Drug Test Only)

Doctor / Hospital Name and Address:

Description of Accident / Incident:

Corrective Actions taken to prevent recurrence:

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Also complete the reverse side (or page 2) if the accident involves a motorized vehicle

Employee's Signature: ________________________________

Person Completing Form: ____________________________  Contact Phone #: ____________________________
Complete this form if the accident/incident is related to a motorized vehicle.

### COUNTY VEHICLE:
- Driver:
- Address:
- Telephone:
- Driver's License:
- Date of Birth:
- Owner of Vehicle:
- Make, Model, & Year of Vehicle:
- Tag Number:
- County Vehicle ID#:

### OTHER VEHICLE:
- Driver:
- Address:
- Telephone:
- Driver's License:
- Date of Birth:
- Owner of Vehicle:
- Make, Model, & Year of Vehicle:
- Tag Number:

### LOCATION OF ACCIDENT / INCIDENT:

### DESCRIPTION OF ACCIDENT:

### Witness(es)
- Name: Name:
- Address: Address:
- Phone #: Phone #:

Person Completing Form: ___________________________ Phone #: ___________________________
Handling an Employee Injury

Employee reports an injury to their Supervisor.

Supervisor notifies the Personnel Director or Safety Director of the injury and discusses treatment options.

“Record Only”
- Incident does not require treatment at that time but the employee wants to report it in case of future problems
- Supervisor fills out a Houston County Accident/Incident Report and forwards it to Personnel (Kristin Gilley). She will fill out an Alabama Worker’s Compensation First Report of Injury report and notes “Record Only” on it and submit it to our Worker’s Compensation carrier.

First Aid or Minor injury
- Supervisor can use the First Aid kit in the area to treat the injury
- Supervisor fills out an Accident/Incident Report and forwards it to Personnel /Sheriff’s Office. A First Report of Injury in “Record Only” status will be sent to w.c. carrier.
- If injury treatment is questionable, call Personnel or the Safety Director to discuss options.

Medical Treatment
- If the injury requires off site medical treatment, the employee should be taken to Houston County’s occupational medical provider, OccMed Solutions. All non life threatening injuries should be treated here initially. If the injury requires specialty treatment, OccMed Solutions will refer the employee to the appropriate specialist and assist them in getting a timely appointment. If an injury occurs after OccMed Solutions’ normal business hours (M-F 8:00am – 5:00pm), and it is not life threatening, the “on call” medical professional can be contacted to meet the supervisor and injured employee at their office.
- A drug test/breath alcohol test should be administered at the time of the visit.
- Supervisor fills out an Accident/Incident Report and forwards it to Personnel /Sheriff’s Office. A First Report of Injury will be sent to w.c. carrier.

Serious or life threatening injury
- Call 911 and request Emergency Medical Services (EMS).
- Supervisor should:
  → Contact the Dept. Head, Personnel Director or Safety Director and inform them of the injury and where the employee is being taken, if known.
  → Secure the area where the accident occurred.
  → Document details of the accident scene.
  → Go to the treating medical facility to be available for any questions that might arise about the nature of the accident or injury.
  → The employee should follow up with OccMed Solutions the following day after visiting the ER.

Once the employee’s injuries have been treated, the supervisor should begin the initial accident investigation and complete the Accident/Incident Report. This information should be forwarded to the Safety Director and Personnel on the day of the injury, if at all possible. A First Report of Injury will be completed and sent to our worker's compensation carrier.

Failure to report a workplace injury could result in denial of worker’s compensation benefits or disciplinary action up to and including termination.

Upon discharge from the treating medical facility, the employee should be given a work status report which details any modified duty requirements. The employee must give this to their supervisor prior to them being allowed to return to work.

Contact Information

Personnel Director – Sheri Thompson
Work Phone 334-677-4778
Cell phone 334-618-5600

Safety Director – Kelly Crowell
Work phone 334-677-4784
Work cell phone 334-796-2471

(List of Pharmacies on the back where an employee can get a w.c. prescription filled with no out of pocket expense)
If the employee receives a prescription, s/he should take it to one of the preferred pharmacies listed below. They have the county’s worker’s comp information on file & the employee should not have to pay anything out of pocket.

**Pharmacies**

- **Doctor’s Center Pharmacy** (Hwy 84 by Arby’s)
  4119 West Main Street 334-793-1316
  M-F 8 am – 6 pm, Sat 8 am – 2 pm, Sun 1 pm – 5 pm

- **Circle Pharmacy** (next to SAMC)
  2021 Alexander Drive 334-792-2717
  M-F 8 am – 6 pm, Sat 8 am – 12 pm, Sun – closed

- **Rite Aid** – 3 locations
  1060 South Oates 334-673-2860
  3721 West Main 334-712-6205
  4030 West Main Street 334-792-2261
  M-F 8 am – 8 pm, Sat 9 am – 6 pm, Sun 10 am – 6 pm
Vehicular Accident checklist

Any Houston County employee involved in an on-the-job vehicular accident will be expected to do the following unless injuries or other circumstances prevent them from doing so:

- Immediately stop your vehicle. Do not leave the accident scene. (If it appears that the other vehicle is not going to stop, try and get a tag number and a description of the vehicle).
- Activate your emergency flashers. Warning signals and lights may be turned on. Rotating beacon(s) may be used – if vehicle is so equipped.
- Exit your vehicle if safe to do so.
- Take whatever actions that can be done safely to prevent another accident from occurring. If you must move your vehicle for safety reasons, take a photo of the scene first.
- Deploy warning flags, reflector triangles or other emergency equipment if the accident scene is in a high traffic area.
- Call 911 to report the accident and provide pertinent information concerning the accident.
- Notify your supervisor immediately.
- Drivers should inquire if anyone is hurt or needs medical attention and assist if possible.
- Do not admit negligence or liability or give your opinion on the accident. Do not attempt settlement, regardless of how minor.
- While waiting for Law Enforcement to arrive, gather information for the accident investigation such as photographs of the scene & damage to vehicles involved. Witness names, addresses and phone numbers should be obtained, if possible. A Houston County Accident/Incident Investigation Form can be used for this (attached).
- DO NOT leave the accident scene until law enforcement has responded.
- Information on the County vehicle and insurance letter is located in the glove box of the vehicle.
- Drivers should keep their up-to-date drivers license and CDL card (if applicable) with them when they are operating a county vehicle.
- Drivers should speak freely and accurately to law enforcement personnel.
- Once the law enforcement investigation is completed, the driver will be taken by his/her supervisor for a drug screen and blood alcohol test as required by the Houston County Employee Handbook.
- All personal injuries to an employee shall be reported immediately to the Supervisor, Personnel Department, and the Safety Director following the procedures outlined in the Handling Employee Injuries Summary Sheet (attached)
- Employees and supervisors who fail to report accidents involving county vehicles shall be subject to disciplinary action. These offenses shall be treated as a Group II Offense in accordance with the Houston County Employee Handbook.