# NOTICE OF SUBCONTRACTOR AWARD (NOA)

# Notice of Subcontractor Award

**To:** **Aon Client Service Center**
**Email:** **acs.construction@aon.com**
**Phone:** **(866) 222 – 4438, option 5**
**CC:** **Benjamin.stone@aon.com**

The subcontractor named below will be issued a contract to perform work on the
Following Project: **Jackson Health System**
(Please identify A-F) **Project F – Rehab Center**
Contract Number: ______________________

☐ Check here if the OCIP Insurance Manual was sent to the subcontractor.
☐ Check here if the subcontractor is to be enrolled in the OCIP
☐ Check here if the subcontractor is to be excluded from the OCIP

| 1. Name of Subcontractor: | |
|---|---|
| 2. Subcontractor Address: | |
| | |
| 3. Subcontractor FEIN #: | |
| 4. Subcontractor Contact Person: | |
| 5. Subcontractor Phone Number: | |
| 6. Subcontractor Email Address: | |
| 7. General Description of Work Included: | |
| 8. Contract Value: | |
| 9. Date of Award: | |
| 10. Anticipated On-Site Start Date: | |

# Notice of Subcontractor Award (NOA)

- NOA’s let Aon know who has been awarded
- NOA’s begin Aon’s process
- Allows Aon to correspond directly with contractors
  - Once an NOA is received, Aon provides the awarded contractor contact with Aon wrap access, login & password
- GC/CM completes and forwards to Aon a NOA for every contract they issue
  - Required for every prime tier Contractor (or Vendor) if they are required to provide insurance.
  - In addition to Standard Contract subs, this may include PO’s, BRA’s, PSA’s etc.
- Prime Contractors must complete NOA’s for every contractor they hire
- NOA’s can be completed on line or can be sent directly to: ACS.Construction@aon.com with a cc to Donna.Perez@aon.com
  - **All documents to ACS must show “Project Name & Contractor Name” in the subject line of the e mail**

# ENROLLMENT APPLICATION FORM 3

**AON** **Form-3**

# ENROLLMENT APPLICATION

Numbers reference attached instructions

**JACKSON HEALTH SYSTEM**
**MIRACLE BUILDING PROGRAM**
**10504246- Project C - Main Campus**



Examine your current Workers Compensation and General Liability Policies or contact your Insurance Agent to assist you with completing this form. *** **NOTICE** *** Enrollment is not automatic and requires the satisfactory completion of the Aon Form-1a or Form-1b, Form-2 and Form-3. In addition, submit a Certificate of Insurance providing evidence of your *off-site* coverage. Please refer to the Insurance Manual for coverage requirements.

## A. Contractor Information:

Federal ID # or Soc. Sec. #: 1 ____________________

| | Business Information *(headquarters)* | Contact Information *(address questions to..)* |
|---|---|---|
| Company Name & dba: / Contact Name & Title: | 2 | 3 |
| Address: | | |
| City, State Zip Code: | | |
| Telephone: | | |
| Fax: | | |
| E.mail Address: | | |

Indicate your Organization's Structure: 4 ☐ Corporation ☐ Partnership ☐ S-Corporation ☐ Joint Venture ☐ Sole Proprietor ☐ Other ____________

## B. Contract Information:

Contract No.: 1 ____________________

Date Contract Awarded: 2 ____________________

Description of Work: 3 ____________________

Proposed Contract Price $: 4 ____________________ Are you Submitting a bid to Skanska?: 6 ☐ Yes ☐ No

Amount of Self Performed Work $: 5 ____________________ If No, identify to whom: 7 ____________________

Start Date: 8 ____________ ☐ Actual ☐ Estimated Completion Date: 9 ____________ ☐ Actual ☐ Estimated

## C. Contacts: *(Complete if Applicable)*

| Position | 1 Name & Title | 2 Phone | 3 Fax | 4 e.mail address |
|---|---|---|---|---|
| Project Mngr: | | | | |
| Res. Engineer: | | | | |
| Insurance: | | | | |
| Contract Admin: | | | | |
| Payroll: | | | | |
| Claims: | | | | |
| Safety Rep: | | | | |

*Provide Location of payroll records if different than Corporate address:* 5 ____________________ Phone: ____________

City, State, Zip Code: ____________________ Fax: ____________

## D. Workers Compensation Insurance Information for Work Described Above: *(attach a separate sheet if necessary)*

| a State | b Class Code | c Description | d Man-hours | e Payroll |
|---|---|---|---|---|
| 1 | | | | |
| | | Totals | 2 | 3 |

## E. Provide your current *Off-Site* Workers Compensation Information: *(for each state you will perform work in)*

| Applicable State | Risk ID Number | Rating Bureau | Anniversary Rating Date |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

Your WC Insurance Carrier: 5 ____________________

Policy #: 6 ____________ Effective Date: 7 ____________ Expiration Date: 8 ____________

# Enrollment Form – Form 3

- Contractor's application for insurance (2 page form)
- Every enrolling sub of every tier must complete a Form 3
- Individual Form 3 is required for each contract contractor has on site
  - If you have multiple contracts you need to enroll separately for each contract
- Contractor MUST be enrolled prior to site mobilization
- Project site access is prohibited without completing the enrollment process

# Enrollment Process

- **Subcontractor provides Aon with Form 3 prior to mobilization**
  - Can be completed on line at www.aonwrap.aon.com
    or sent directly to ACS.Construction@aon.com
  - Aon submits Form 3 to Insurance Carrier
  - Must be accepted by the Insurance Carrier for coverage to apply
- **Upon acceptance, Aon notifies Subcontractor via 'Welcome Letter'.** CM/GC Project Manager also receive copy of the letter.
  - Welcome letters provide OCIP Certificate
  - **SAVE the certificate and give it to your broker/agent for your Insurance Policy Audit!**
- **Contractor specific WC policy will be issued and sent shortly after Welcome letter**
  - **SAVE the policy and give it to your broker/agent for your Insurance Policy Audit!**
- **At anytime during the process, Aon is available to assist with completing forms**

# ENROLLMENT APPLICATION

Numbers reference attached instructions



**F. Subcontract Information:** List **all** Subcontractors that will be working for you on this project (complete the information in the following table). Use additional paper if necessary:

| 1 *Subcontractor* | 2 **Contract Value** | 3 **Contact Person** | 4 **Phone #** | 5 **Email** | 6 **Estimated Start Date** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**G. Enrollment Questions:** ***Answer*** each question. Use additional paper if necessary.

1 Will you have any off-site location(s) 100% dedicated to this project? ☐ Yes ☐ No If yes, please provide address:
None

2 Please check if: No Any aircraft used on this project No Any watercraft used on this project

3 Please indicate if labor from the following sources will be used: No Employee Leasing Firm No Temporary Labor Agency

4 What is your current Experience Modification Rate (EMR)? ____________________

**H. WARRANTY APPLICABLE TO PROGRAM INSURANCE COVERAGE**

1 Premiums for this Program are the responsibility of *Jackson Health System* and I agree any and all return of premium, dividends, discounts, or other adjustments to any Program policy(ies) is assigned, transferred and set over absolutely to *Jackson Health System*. This assignment applies to the Program policy(ies) as now written or as subsequently modified, rewritten or replaced. Rights of Cancellation for all Program insurance policy(ies) arranged by *Jackson Health System* are assigned to *Jackson Health System*.

2 I will pay the cost of premium(s) for non-Program insurance coverage, specified in the Contract Documents.

3 I authorized the release of all claim information for all insurance policies under this Program.

4 It is my responsibility to notify my insurance carrier(s) that I am enrolling in this Program.

5 I have excluded from my bid the insurance costs for the coverage provided by *Jackson Health System*. I further agree to the Aon Verified Insurance Cost Amount and Rate as described in the Insurance Manual.

6 The statements in this insurance application are true to the best of my knowledge.

**I. Signature Block :** I **verify** the information presented above and attachments are correct:

Name: ______________________ Date: ______________________
**(please print)**
Title: Signature:

**Note:** Information can be submitted on-line at www.aonwrap.aon.com. Please contact your Administration Staff to obtain a user ID and Password.

# INSURANCE COST WORK SHEET
# FORM 1

AON Form-1a

# INSURANCE COST WORKSHEET

(Fixed Price Type Contracts)

Numbers reference attached instructions

JACKSON HEALTH SYSTEM MIRACLE BUILDING PROGRAM
10504246- Project C - Main Campus



## A. Contractor Information:

Federal ID # or Soc. Sec. #: 1

| | Business Information *(headquarters)* | Contact Information *(address questions to..)* |
|---|---|---|
| Company Name & dba: / Contact Name & Title: | 2 | 3 , |
| Address: | , | |
| City, State, Zip Code: | | |
| Telephone: | | |
| Fax: | | |
| E.mail Address: | | |

## B. Bid Information:

Bid Package 1 /

Description of Work: 2

Proposed Contract Price $: 3

Amount of Self Perfomed Work $: 4

Are you Submitting a bid to Skanska?: 5 ❑ Yes ❑ No

If No, identify to whom: 6

## C. Workers' Compensation Insurance Information for Work Described Above: (a) *(attach a separate sheet if necessary)*

| a<br>State | b<br>Class Code | c<br>Description | d<br>Rate<br>*(per $100 payroll)* | e<br>Man-hours | f<br>Payroll | g<br>WC Premium<br>*(Payroll * Rate / 100)* |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | **Totals** | 2 | 3 | 4 |

Identify the Amount of Your Claim Retention 5

Your Company's Workers' Compensation Experience Modifier: 6

Modified Premium *(line C4 x C6)*: 7

Employers Liability Rate: 8

Employers Liability Premium: 9

| 10 Modification & Discount Premium Factors | | 11 Rate | 12 Amount |
|---|---|---|---|
| Mod 1: | + or - | | |
| Mod 2: | + or - | | |
| Mod 3: | + or - | | |
| Mod 4: | + or - | | |
| Mod 5: | + or - | | |

**Total Modification Amount** *(Total of all amounts entered in column C12)*: 13

Total Workers' Compensation Premium *(line C7 + C9 + C13)*: 14

## D. General Liability: (a)

Rate: 1

2 Based On:
❑ Total Payroll (C3)
❑ Contract Price (B3)
❑ Other

3 Rate factor:
❑ Per 100
❑ Per 1,000

4 Identify the Amount of Your Claim Retention: __________

GL Premium *(D2 x D1 ÷ D3)*: 5

**Excess/Umbr Liab:** (a)

Rate: 6

7 Based On:
❑ Total Payroll (C3)
❑ Contract Price (B3)
❑ Other

8 Rate factor:
❑ Per 100
❑ Per 1,000

Excess/Umbr Premium *(D7 x D6 ÷ D8)*: 9

## E. Totals

Total of all Insurance Premiums *(Total of lines C14 + D5 + D9 + E3 + F1)*: 1

Overhead & Profit on Insurance Prem. %: 2 15%

O/H & Profit Amount *(G1 x G2)*: 3

**Total Initial Insurance Cost** *(Total of lines G1 + G3)*: 4

**Contractor's Initial Insurance Cost Rate** *(Line G4 divided by total Contract Price in line B3 x 100)*: 5

## F. Signature Block: I verify the information presented above and attachments are correct:

Name: __________ (please print) Date: __________

Title: __________ Signature: __________

**Completion of this form is a required part of your bid and must accompany your bid documents.** Complete a separate form for each contractor, known subcontractor(s) and trades not currently awarded to a subcontractor. Duplicate this form as needed.

(a) **Please provide copies of the following documents to support your insurance cost calculations:**

- ☑ Workers' Compensation declaration and rate pages
- ☑ Umbrella/Excess Liability declaration and rate pages
- ☑ General Liability declaration and rate pages

# Insurance Cost Work Sheet – Form 1

- **All Enrolled Contractors complete a Form 1**
  - Can be completed on line at www.aonwrap.aon.com
    or sent directly to ACS.Construction@aon.com
- Individual Form 1 required for each Contract/Subcontract
- All Contractors provide Aon with copies of rate pages from their own General Liability, Workers Comp & Excess/Umbrella policies
- **Contracts are Bid Net with Add Alternate**
  – Cost verification is used to establish the Sub's Actual Insurance Cost
  – Contract adjustments are not made
- Verified Costs provide indication to the Sponsor of what the Contractors insurance would have cost if Contractor had provided their own insurance under Traditional/Non OCIP program
- This should closely represent savings on your own insurance premiums
  – **Carriers cannot audit exposures covered by another policy**

**Each OCIP Manual includes a Cost Worksheet Form**

– **See Section 8, Page 19; instructions on Page 20 of JHS Manuals**

# ON-SITE PAYROLL REPORT
# FORM 4

# On-Site Payroll Report – Form 4

- **Contractors report payroll on line at www.aonwrap.aon.com**
- Individual Form 4 required for each contract
- Due by 10th of the following month
- **Bare labor expended on-site**
  - NO off-site payroll
  - Summed and reported by Workers' Comp Class Code
- **NOT certified payrolls!!!**
- **If not performing work on-site for month(s), $0.00 MUST be submitted**
- **All payrolls you report are reported to the OCIP carrier**
  - Carrier reports these to WC board to promulgate your companies future Modification (EMR)
- **Save a record of the payrolls you report under the OCIP**
  - You will need to provide that information to your own WC or GL carrier to make sure you are not charged for that exposure
  - contact your Agent or Broker to determine in advance of audit to determine exactly what will be needed

# CERTIFICATE OF LIABILITY INSURANCE

# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): CURRENT DATE

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

**PRODUCER** Insurance Agent's Name and Address

Telephone Number:

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:

**INSURED** Subcontractor's Name and Address

Sample Certificate for ENROLLED PARTIES

| INSURER(S) AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A : | |
| INSURER B : | |
| INSURER C : | |
| INSURER D : | |
| INSURER E : | |
| INSURER F : | |

**COVERAGES** **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | TYPE OF INSURANCE | ADDL INSR | SUBR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS |
|---|---|---|---|---|---|---|---|
| | **GENERAL LIABILITY**<br>X COMMERCIAL GENERAL LIABILITY<br>CLAIMS-MADE X OCCUR<br>GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC | Y | Y | Policy Number | | | EACH OCCURRENCE $1,000,000<br>GENERAL AGGREGATE $2,000,000<br>PRODUCTS & COMPLETED OPS $2,000,000<br>PERSONAL & ADV INJURY $1,000,000<br>FIRE DAMAGE $<br>MEDICAL EXPENSE $ |
| | **AUTOMOBILE LIABILITY**<br>X ANY AUTO<br>ALL OWNED AUTOS<br>SCHEDULED AUTOS<br>X HIRED AUTOS<br>X NON-OWNED AUTOS | Y | Y | Policy Number | | | COMBINED SINGLE LIMIT $1,000,000<br>BODILY INJURY (Per person)<br>BODILY INJURY (Per accident)<br>PROPERTY DAMAGE |
| | **UMBRELLA LIAB** X OCCUR<br>**EXCESS LIAB** CLAIMS-MADE<br>DED RETENTION $ | Y | Y | Policy Number | | | EACH OCCURRENCE $5,000,000<br>AGGREGATE $5,000,000 |
| | **WORKERS COMPENSATION AND EMPLOYERS' LIABILITY**<br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N X<br>**(Mandatory in NH)**<br>If yes, describe under DESCRIPTION OF OPERATIONS below | N/A | Y | Policy Number | | | X WC STATUTORY LIMITS OTHER<br>EL Each Accident $ 500,000<br>EL Disease Policy Limit $ 500,000<br>EL Disease Each Accident $ 500,000 |
| | Other | | | Policy Number | | | Per Claim/Occurrence $<br>Aggregate $ |

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES: JACKSON HEALTH SYSTEM – MIRACLE BUILDING PROGRAM** Project C- Main Campus

THE PUBLIC HEALTH TRUST, AN AGENCY AND INSTRUMENTALITY OF MIAMI-DADE COUNTY, FLORIDA AND ANY OTHER ENTITIES AS REQUIRED BY OWNER CONTRACT, THEIR PARENT, SUBSIDIARIES AND AFFILIATED ENTITIES, AND FOR EACH OF THE FOREGOING, ALL OFFICERS, DIRECTORS, MEMBERS, AGENTS, REPRESENTATIVES, PERSONNEL AND EMPLOYEES, AND SUCH OTHER PARTIES AS OWNER MAY DESIGNATE, SKANSKA USA BUILDING INC., SKANSKA USA INC INDEMNIFIED PARTIES ARE NAMED ADDITIONAL INSURED'S ON A PRIMARY AND NON-CONTRIBUTORY BASIS ON THE GENERAL LIABILITY, AUTO LIABILITY AND EXCESS/UMBRELLA POLICIES. A WAIVER OF SUBROGATION EXISTS IN FAVOR OF ALL ADDITIONAL INSURED'S AND ANY OTHERS AS REQUIRED BY CONTRACT WITH REGARDS TO ALL POLICIES. EXCESS/UMBRELLA FOLLOWS FORM.
ALL COVERAGES LISTED ABOVE APPLY TO OFF-SITE OPERATIONS ONLY OF THE NAMED INSURED, WITH THE EXCEPTION OF AUTOMOBILE WHICH APPLIES TO ONSITE & OFFSITE.

**CERTIFICATE HOLDER**

THE PUBLIC HEALTH TRUST, AN AGENCY AND INSTRUMENTALITY OF MIAMI-DADE COUNTY, FLORIDA
c/o Aon Risk Solutions
4 Overlook Point
Lincolnshire, IL 60069
acs.construction@aon.com
Client # 10504246 - Project C- Main Campus

**CANCELLATION**

**SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.**

*AUTHORIZED REPRESENTATIVE*

# Who Needs to Provide A Certificate of Insurance?

- **All Enrolled and Excluded Contractors**
- Notice of Award received from GC/CM outlines insurance coverages required of contractor
- Aon reviews all Prime Contractor Certificates
  - Certificates needed from start date to completion date
- **Prime Tiers are responsible for monitoring their Lower tier Insurance Coverages**

**Each OCIP Manual includes Sample Certificates**

**– See Section 8: Enrolled Contractors, Page 24; and Excluded Contractors, Page 25 of JHS Manuals**

# Certificate Requirements

Often certificate requirements are the same as those required under a Traditional/Corporately written project

**For COIs, the usual minimum items:**

- **Provides evidence of Contractor's own General Liability, Workers Comp, Auto & Excess/Umbrella policies**
- **Not expired** (valid for current period)
- **Correct Additional Insureds are listed**
- **Correct limits per Contract Agreement**
- **Endorsement CG 20 10 referenced or physically attached**

**If requirements cannot be met or Company does not carry the required coverages, limits or extra endorsements,**
**please reach out to Donna Perez.**
**Donna will submit a request for consideration to Jackson Health.**

# CONTRACTOR WORK COMPLETION FORM 5

# Contractor Work Completion – Form 5

- **Every Enrolled Subcontractor must complete a "Notice of Work Completion" on line at www.aonwrap.aon.com**
  - Must be signed by Contractor and approved by GC/CM.
- Excluded subcontractors – No form 5 required
  - Contractor advised Aon when their scope was completed
  - Aon obtains confirmation from GC/CM of completion date
- **Once a contract is closed, re-entry to the site is not permitted**
- Contractor Returning after completion?
  - Contact Aon to reopen contract prior to returning to the site