AMERICAN LIBERTY INSURANCE

EMPLOYER'S CERTIFICATION

ARIZONA ALCOHOL- AND DRUG-FREE WORKPLACE PREMIUM CREDIT

Employer Name: _____

Employer Address: _____

FEIN Number (Required) _____ Policy Period: _____

Contact Name: _____ Policy Number:_____

Telephone Number: _____ Fax Number:_____

Date Alcohol and Drug Testing Program was established:_____

All Named Subsidiaries:_____

All locations Covered:_____

_____

The undersigned employer certifies that the business has established and implemented a policy of an alcohol and drug-free workplace program meeting the requirements of Title 23, Chapter 2, and Article 14 of the Arizona Statutes. By signing this agreement, you have provided sufficient additional information to the insurance company, as required, to confirm a qualifying program has been established and is being maintained.

This certification will apply a 5% premium credit to qualifying employers. This credit will be applied to the employer's policy pro rata as of the date of receipt of this certification by the insurance company. If it is found that these practices are not in place or being maintained in compliance with the provisions of the program, the premium credit granted will be deleted and the employer must reimburse the amount of the premium credit to the insurance company.

To qualify for the premium credit, the employer must:

1. Provide to the insurance company prior to the beginning of the policy period each year, this written statement to certify that the business has implemented a program meeting the requirements of Title 23, Chapter 2, Article 14 of the Arizona Statues
2. Provide the program information to the insurance company, as required to confirm that the qualifying program was established and is being maintained.
3. Comply with the alcohol and drug testing policy requirements in accordance with Title 23, Chapter 2, and Article 14.
4. Comply and conduct alcohol and drug testing of prospective employees in accordance with the program.
5. Comply and conduct alcohol and drug testing of an employee after the employee has been injured.
6. Whenever requested, allow the insurance company to have full access to the alcohol and drug testing results under 4 and 5.

Authorized Employer Representative Signature:_____

Print Name: _____Date: _____
(Officer / Owner and Title)

Please sign and date this form and fax or mail it to: American Liberty Insurance Company
3601 North University Ave, Suite 100
Provo, UT 84604-6600
Fax No. (801) 226-8022

Date Received: _____