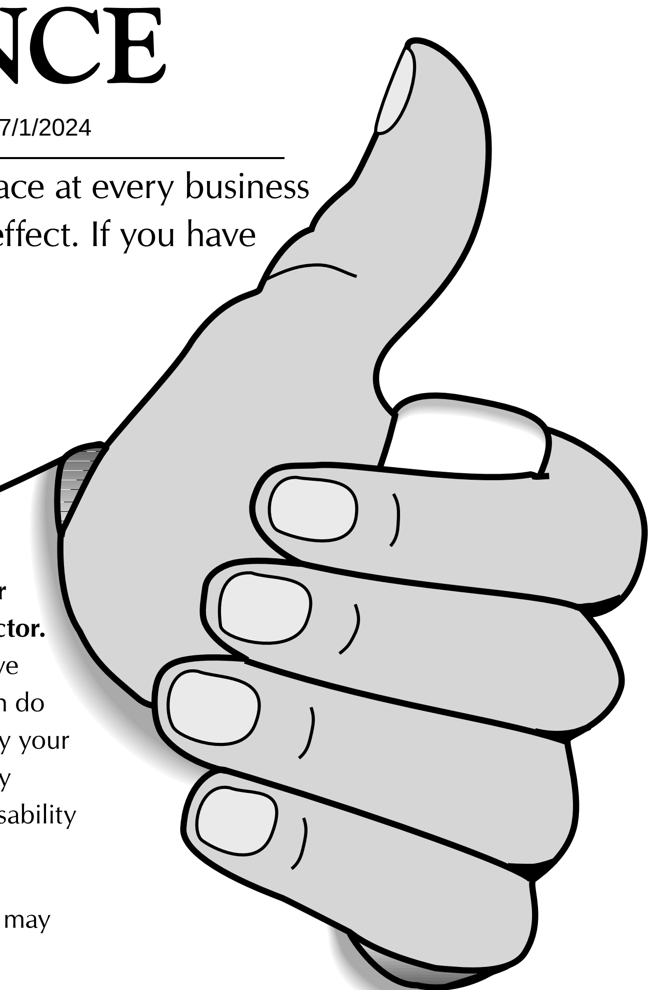
NOTICE OF COMPLIANCE

This employer complies with the Oregon Workers' Compensation Law. Coverage started 7/1/2024 and remains in effect until terminated. Employers must post this notice in a conspicuous place at every business location. It is illegal to permit this notice to remain posted when insurance is no longer in effect. If you have questions or need additional notices: Call (503) 947-7814 or (503) 947-7993/TTY.



Notice to worker:

If you are injured on the job, you should —

1 **Notify your employer right away.** If you seek medical treatment, tell the doctor that you were hurt on the job. Give your doctor the insurer and policy information shown below. A workers' compensation claim can be filed by completing Form 801, available from your employer.

2 **Stay in touch with your employer and your doctor.** Your employer may have light-duty work you can do while you recover. Only your attending physician may authorize temporary disability payments.

3 **If you have questions, contact your employer or the insurer.** You also may contact the Workers' Compensation Division (benefit consultants) at (800) 452-0288 or (503) 947-7993/TTY or the Ombudsman for Injured Workers (advocate) at (800) 927-1271.

Insurer: ACE American Insurance Company
33 Arch Street
Boston, MA 02110

Policy no.: WLR C55653203

Employer: Acara Solutions, Inc.

BIN: **WCD no.:**

Cory Streisinger, Director
Department of Consumer & Business Services

440-1188 (2/06/COM)

Employer: Use the postcard below to make comments or recommendations, to order additional posters, or to order Spanish-language supplements.

You can order online at: www.wcd.oregon.gov

Return name & address

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 1266 SALEM OR
POSTAGE WILL BE PAID BY ADDRESSEE

WORKERS' COMPENSATION DIVISION - EMPLOYER COVERAGE
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE RM 21
SALEM OR 97301-9920

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

Worker: Give this card to the doctor who treats your job injury.
Trabajador: Entregue esta carta al doctor que trata su lesión de trabajo.
Employer:

BIN:
WCD no.: (over)

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Trabajador: Entregue esta carta al doctor que trata su lesión de trabajo.
Employer:

BIN:
WCD no.: (over)

Physician: If you have provided treatment for an on-the-job injury or illness, send Form 827 to:

Insurer:

Policy no.:

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Insurer:

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BIN: **WCD no.:**

Comments or recommendations:

Send____ additional copies of the English-language Notice of Compliance poster.

Send____ copies of the Spanish-language supplement (to be posted beside the English-language poster).

Name:

Address:

City:

State: ZIP:

Phone: Fax: