SECRETARY OF STATE
STATE OF MONTANA

Mike Cooney
Secretary of State

Montana State Capitol
Helena, MT 59620

February 21, 1992

Bud Lilly
2007 Sourdough Road
Bozeman, MT 59715

Re: WESTERN RIVERS CLUB, an assumed business name
Filed -- February 19, 1992
Expires -- May 20, 1997
File 29373-264(2)

Dear Mr. Lilly:

I've approved the filing of the Renewal of the Registration of Assumed Business Name. Enclosed is my official Certificate.

If I can be of further help to you, just let me know.

Sincerely,

Mike Cooney

MC:cb
Enclosure

SECRETARY OF STATE
STATE OF MONTANA

CERTIFICATE OF RENEWAL OF REGISTRATION OF ASSUMED BUSINESS NAME

I, **MIKE COONEY**, Secretary of State of the State of Montana, do hereby certify that the Application for Renewal of Registration of Assumed Business Name **WESTERN RIVERS CLUB**, for a period of five years to expire **May 20, 1997**, duly executed pursuant to the provisions of Section 30-13-207, Montana Code Annotated, have been received in my office and conform to law.

NOW, THEREFORE, I, **MIKE COONEY**, as such Secretary of State, by virtue of the authority vested in me by law, hereby issue this Certificate of Renewal of Registration of Assumed Business Name to **Walen F. Lilly, an individual**, of **Bozeman, Montana**, and attach hereto a copy of the Application for Renewal of Registration of Assumed Business Name.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of the State of Montana, at Helena, the Capital, this February 19, A.D. 1992.

Mike Cooney

MIKE COONEY
Secretary of State

ABN 25—Rev. 12/88

(For use by the Secretary of State only)

Prepare, execute and submit with a fee of $15.00
Statutes require one original and one copy be submitted.

TO: MIKE COONEY
Secretary of State
State Capitol
Helena, MT 59620

RECEIVED
HELENA, MONTANA
FEB 12 9 37 AM '92
MIKE COONEY
SECRETARY OF STATE

29373
STATE OF MONTANA
FILED
FEB 19 1992
SECRETARY OF STATE

I.D. # FOLDER #

Filing Fee: $15.00

RECEIVED
HELENA, MONTANA
FEB 19 9 28 AM '92
SECRETARY OF STATE

STATE OF MONTANA
APPLICATION FOR RENEWAL OF REGISTRATION OF ASSUMED BUSINESS NAME

For the purpose of renewing an Assumed Business Name registration in the State of Montana for a period of five years, according to 30-13-207, MCA, the undersigned submits the following statements of fact to the Secretary of State:

1. The Assumed Business Name to be renewed:

WESTERN RIVERS CLUB

2. The description of the business transacted under the Assumed Business Name: FLY FISHING OUTFITTING AND BOOK SALES

3. The name(s) of the Montana county or counties in which business is transacted: GALLATIN, MADISON, PARK, JEFFERSON AND YELLOWSTONE

4. The name(s) and address(es) (with street name and number and city) of the registrant(s):

WALEN F. LILLY

2007 SOURDOUGH ROAD

BOZEMAN MT 59715

5. The registrant is (check one and complete where appropriate):

☒ An Individual

☐ A Partnership, and the names and addresses of the partners are:

1. _____
2. _____
3. _____
4. _____

(Attach an additional sheet, if needed)

☐ A Corporation organized and existing under the laws of the State of _____

☐ An Association (Attach list of names and addresses of members)

Date of Application: FEBRUARY 11, 1992

(Complete appropriate affidavit on reverse side and submit in duplicate original)

COMPLETE THE ONE AFFIDAVIT THAT IS APPROPRIATE.

- **Affidavit if applicant is a corporation, partnership, or association.**

I,_____, being first duly sworn
(Name of Officer making affidavit)

depose and say that I am_____, of
(President, Vice President or Secretary or a Partner)

_____, the applicant
(Complete Name of Applicant)

herein, and make this affidavit in its behalf; that I have read the foregoing application; that the facts set out therein are true; and the execution of this document constitutes an affirmation, under the penalty of false swearing.

X_____
(Signature)

PLEASE NOTE: The name to be registered can't include the words "corporation", "company", "incorporated", or "limited" or an abbreviation of one of these except when the applicant is a corporation.

★ ★ ★

- **Affidavit if applicant is an individual.**

I, WALEN F. LILLY, being first duly sworn
(Name of Applicant)

depose and say that I am the applicant herein (doing business as WESTERN RIVERS CLUB); that I have read the foregoing application; that the facts set out therein are true; and the execution of this document constitutes an affirmation, under the penalty of false swearing.

x Walen F Lilly
WALEN F. LILLY (Signature)

PLEASE NOTE: The name to be registered can't include the words "corporation", "company", "incorporated", or "limited" or an abbreviation of one of these except when the applicant is a corporation.

State Compensation Insurance Fund
Division of Worker's Compensation
P.O. BOX 4759
HELENA, MONTANA 59604

A. G. PILLEN
BUREAU CHIEF

DEC 14 1982

UNDERWRITING
449-3184

CLAIMS
449-2047

3-83506-3
WALEN G LILLY
WESTERN RIVERS CLUB
%PO BOX 1941
BOZEMAN MT 59715

We wish to take this opportunity to welcome you to the State Compensation Insurance Fund. By enrolling under the Workers' Compensation Act, you have protected yourself from possible liability in the event of an accidental work related injury to one of your employees. Your employees, at no expense to them, are assured of medical and compensation benefits to the limits provided by the law.

Compensation is paid to an injured worker for temporary disability during the recovery period and additional compensation may be paid should a worker suffer a permanent physical disability. In the event of a fatal injury, the spouse and dependent children are also entitled to compensation.

Unlimited medical and hospital care are provided. An injured employee may choose his initial treating physician. Treatment is allowed by other medical specialists by referral of the treating physician or the State Insurance Fund.

We have enclosed several documents with which you should become familiar.

1. Your approved Insurance Policy (Form 300) and any applicable endorsements that may be attached should be retained in your permanent records.

2. The code, classification, and rate schedule attached to your policy identifies the classification codes assigned to your firm based on information provided in your application. In the near future you will receive your first payroll report, and you should report all your employees wages under the appropriate classification code. These same codes will be pre-printed on your payroll report along with instructions explaining how to prepare and submit the report. You will automatically receive payroll reports at the end of each reporting period. Premium, based on actual wages reports, will be billed upon receipt of the payroll reporting form. You must report every period, even if there are no employees, in which case no premium will be billed.

3. The blank copies of the "Employer's First Report of Occupational Injury or Disease and Claim for Compensation" (Form 37/54A) are enclosed for your convenience. Additional forms can be obtained from our office. The law requires an employer to submit a report immediately after an industrial injury occurs even if you believe the injury was not job related. If you dispute the injury, please indicate on the form or by an attachment the reason for your dispute. Disputed cases are investigated by our field representatives.

The following employments are exempt from coverage under the Workers' Compensation Act unless the employer specifically elects coverage by endorsement to the policy:

1. The sole proprietor of a business.
2. Working partners of a partnership devoting full time to the business.
3. Members of the employer's immediate family (husband, wife, son or daughter) dwelling in the employer's household. This provision applies to sole proprietorship and partnership entities only. Family members working for corporate entities are included as employees by law.
4. Household and domestic employees who tend only to the aid and comfort of the members of the employers family.
5. Casual employment.

If coverage for any of the exempted employments listed above is desired, be sure to request endorsement forms. The endorsement forms must be completed and approved by the Fund as part of your policy before coverage can be effective. Reporting payroll for exempted employments does not extend coverage unless the necessary endorsements have been previously filed and approved.

You must promptly notify us of any changes in ownership of your business from its present status to a sole proprietorship, partnership or corporation. Please refer to your policy number when corresponding with us.

We sincerely hope our services will be satisfactory. If you have any questions or problems, contact us at the above address or phone 449-3184.

Very truly yours,

A. G. PILLEN
Bureau Chief

AGP/vj

Enclosure

STATE COMPENSATION INSURANCE FUND
DIVISION OF WORKERS' COMPENSATION
P. O. BOX 4759
HELENA, MT. 59604-4759

TELEPHONE (406) 449-3184

WORKERS' COMPENSATION AND OCCUPATIONAL DISEASE

Western Rivers Club
% Neil, Williamson & Co
Box 1941
Bozeman, Mt 59715

INSURANCE POLICY

► 3-83506-3

The Montana State Compensation Insurance Fund (herein Fund), in consideration of the total initial deposit stated in the Declarations of this policy and of premiums paid upon the total remuneration of employees during each reporting period, does hereby agree with the Employer named in the Declarations of this policy, herein also called the insured, as follows:

Section A
INSURING AGREEMENTS

The Fund hereby agrees:

1. To assume the entire liability of the insured to his employees under the Workers' Compensation Act of Montana, as amended, and as may be amended, and including the Occupational Disease Act, as amended, and as may be amended. (See exceptions under "Exclusions".)

2. To defend, on behalf of the insured, such claims and suits which may at any time be instituted against him under the Workers' Compensation Act or Occupational Disease Act of Montana for injuries or diseases originating during such periods as this policy may be in effect; but the Fund may make such investigation, negotiation and settlement as it deems expedient.

Section B
EXCLUDED EMPLOYMENT AND RISKS:

This policy DOES NOT apply:

1. To:
   (a) federal employment,
   (b) any person performing services in return for aid or sustenance only,
   (c) employment with any railroad engaged in interstate commerce (except that railroad construction work shall be covered under this policy);
2. To the following types of employment UNLESS these employments are specifically described in the Declarations of this policy or in written endorsement to this policy:
   (a) casual employment,
   (b) household and domestic employment,
   (c) employment of members of an employer's family dwelling in the employer's household,
   (d) employment of sole proprietors or working members of a partnership.
3. To corporate officers who have rejected coverage by giving proper notice to the Division of Workers' Compensation in compliance with the appropriate laws and regulations therefor, and whose names appear as such on the declarations or endorsements to this policy.
4. To any liability which an employer named as insured in the policy may have as an owner, member or associate of any partnership, association or organization not named as an insured in the Declarations or endorsements.

Section C
CONDITIONS

1. The Contract.

All of the provisions of the workers' compensation and occupational disease laws and regulations of Montana, as amended, or as may be amended, shall be a part of this policy as fully and completely as if written herein.

This policy, including the Declarations and endorsements, and the application, constitutes the entire contract of insurance. By acceptance of this policy, the insured agrees that the statements in the Declarations and endorsements are his agreements and representations, and that this contract embodies all agreements existing between the insured and the Fund. Any material misrepresentations by the insured in the application or appearing on the Declarations or endorsements may render the contract void.

2. Changes.

No provision of this policy shall be waived or altered except upon endorsement signed by a duly authorized representative of the Fund, EXCEPT: (1) those changes specifically authorized in paragraph 4; and (2) changes in this policy necessitated by any change in the laws of Montana, in which case thirty (30) days notice shall be given the insured of such change.

3. Payroll Information.

The insured shall keep complete and accurate records of the remuneration earned by all officials and employees, classified according to the codes assigned in Schedule A. At the request of the Fund, the insured shall furnish immediately all earnings of every kind of all employees and officials during any period in which this policy is in effect for computation of premium. All remuneration of employees shall be included for computation of premium at the value specified by the manuals in use by the Fund.

STATE PUBLISHING CO., HELENA, MONT.

STATE COMPENSATION INSURANCE FUND
DIVISION OF WORKERS' COMPENSATION
TELEPHONE (406) 449-3184 P. O. BOX 4759 HELENA, MT. 59604-4759

COVERAGE DECLARATIONS FOR
WORKERS' COMPENSATION AND OCCUPATIONAL DISEASE INSURANCE

DATE ISSUED 12-13-82 **EMPLOYER NOTE:**

INSURED

NAME AND MAILING ADDRESSES
Western Rivers Club
% Neil, Williamson & Co
Box 1941
Bozeman, Mt 59715

POLICY COVERS

COVERAGE EFFECTIVE ►	INITIAL DEPOSIT ►	REPORT BASIS ►	POLICY NUMBER ►	ENTITY CODE ►
11-3-82	25.00	Q	3-83506-3	7

REPORTING BASES ► Q = QUARTERLY; S = SEMIANNUAL; M = STATE CENTRAL PAYROLL

ENTITY CODES ► 1 = FEDERAL; 2 = STATE; 3 = LOCAL; 4 = INTERNATIONAL; 5 = PRIVATE SECTOR, OTHER; 6 = CORPORATION; 7 = SOLE PROPRIETOR; 8 = PARTNERSHIP; 9 = JOINT VENTURE

ALL USUAL NAMES AND USUAL WORK PLACES OF THE INSURED AT OR FROM WHICH OPERATIONS COVERED BY THIS POLICY ARE CONDUCTED ARE LOCATED AT THE ABOVE ADDRESS UNLESS OTHERWISE STATED BELOW:

same

OTHER COVERAGES

THE FOLLOWING COVERAGES ARE CONSIDERED IN FORCE AND REMUNERATION MUST BE REPORTED AS REQUIRED BY DIVISION RULE AND ACCORDING TO THE STATUTES OF THE STATE OF MONTANA. PLEASE REFER TO SECTION B OF YOUR POLICY.

ALL HOUSEHOLD EMPLOYEES ☐ FAMILY MEMBERS ☐ SOLE PROPRIETOR ☐ WORKING PARTNERS ☐ CORPORATE OFFICERS ☐ CASUAL EMPLOYMENT ☐

NAMES OF COVERED FAMILY MEMBERS	DATE COVERAGE EFFECTIVE	DATE TERMINATED
none		

NAMES OF OFFICERS, PARTNERS OR OWNER	COVERAGE PROVIDED YES	COVERAGE PROVIDED NO	DATE COVERAGE EFFECTIVE	DATE TERMINATED
Walen Lilly owner		X		

MISC.

SCHEDULES AND ENDORSEMENTS ATTACHED TO THE DECLARATIONS ARE AS FOLLOWS:

Schedule

STATE COMPENSATION INSURANCE FUND
DIVISION OF WORKERS' COMPENSATION
P.O. BOX 4759
HELENA, MONTANA 59601

DATE 12-13-82
FIRM NO. 3-83506-3

Schedule 100

The classification code(s) and corresponding rate(s) (underlined below) have been assigned to your firm in accordance with the job description(s) provided by your firm to the State Fund.

The payroll of any one employee should not be divided between two or more classifications. The entire payroll of each employee should be assigned to the highest rated classification representing any part of his work.

CODE NO.	CLASSIFICATION CODE DESCRIPTION	RATE PER $100.00 PAYROLL
8810-1	CLERICAL OFFICE EMPLOYEES N.O.C. Employees whose duties are confined to keeping the books or records of the employer, performing duties as office draughtsmen, conducting correspondence, or who are engaged wholly in office work, having no other duty of any nature in or about the employer's premises. If any clerical office employee is exposed to any operative hazard of the business, his entire payroll shall be assigned to the highest rated classification of work to which he is exposed. This classification is only for persons working exclusively in separate buildings, or on separate floors of buildings, or in areas which are separated from all other work by structural partitions.	.28
8742-1	Claim Adjusters or Special Agents - Insurance Company	
8742-2	Real Estate or Insurance Agency - Outside Employees & Collectors Care, custody and maintenance or construction to be separately rated.	
8742-3	Salesmen, Collectors or Messengers - Outside. Employees engaged in any duties away from the premises of the employer, except employees whose duties include the delivery of any merchandise handled, treated or sold. This classification is applicable to salesmen taking book orders only.	.75
8742-4	Attorney or Lawyer Includes travel away from office.	
8742-5	Accountant, CPA, LPA NOC	
9015-1	Bath House - Beach	
9015-2	Buildings N.O.C. - operation by owner or lessee. This classification is to be used for employees engaged in janitorial or maintenance type work.	3.35
9015-3	Camp Operation - Recreational or Educational including Clerical	

For classifications, codes and rates for any operations not represented above, write or otherwise contact the State Compensation Insurance Fund.

Failure on the part of the insured to provide payroll information at the request of the Fund shall entitle the Fund to estimate payroll based on previous payroll information supplied by the insured to the Fund.

4. Premium.

This policy is accepted by the insured subject to the classifications and rates found in the manuals in use by the Fund. Classifications noted in the Declarations are based on information supplied to the Fund by the insured. If any employees at any time commence doing work properly falling within another classification, or if at any time the Fund discovers that any employee is or has been doing work other than that reported, the proper classification shall become effective on the date the said work commenced. Otherwise, changes in the rates and classifications shall become binding on the insured after thirty (30) days notice.

The insured shall pay the initial deposit on the inception of this policy, which shall be retained by the Fund to be applied to any final billing upon termination of this policy. The Fund may, from time to time, adjust the amount of deposit required as deemed necessary to cover premiums. Interim premiums shall be computed in accordance with the manuals in use by the Fund at intervals specified in the Declarations. Premiums become due upon billing, and the insured is subject to cancellation of this policy by the Fund thirty (30) days after billing in the event of nonpayment.

5. Audit and Adjustment of Premium.

Any authorized representative of the Fund shall have the right and opportunity during the effective dates of this policy and at reasonable times thereafter to examine and audit the insured's records so far as they relate to remuneration earned by employees. If it shall be ascertained by the Fund at any time that the total premium paid by the insured is less than is properly chargeable to the insured under the terms of this policy, the insured shall promptly pay to the Fund at its office in Helena, Montana, the difference between the total premium paid and the ascertained premium. If the total premium paid by the insured is in excess of the ascertained premium, the Fund shall, at the option of the insured, immediately credit the account of, or pay the amount of such excess premium to the insured.

6. Subcontractors.

If the insured shall contract or subcontract any work to contractors or subcontractors, the Fund may, at its option, require remuneration of all employees of any such contractor or subcontractor to be included in the remuneration on which premium is paid by the insured, provided such contractor or subcontractor has not secured compensation insurance for its employees as required by the workers' compensation law.

7. Cooperation of the Insured.

The insured shall cooperate with the Fund by: (1) permitting the Fund or the Fund's representative to inspect at any reasonable time the workplace and operations covered by this policy; (2) permitting the Fund to examine and audit payroll records, general ledger, disbursements, vouchers, contracts, tax reports and all other books, documents and records of any and every kind at any reasonable time during the policy period, and within a reasonable time thereafter, as far as said documents relate to the subject matter of this insurance; (3) give the Fund written notice within six (6) days of discovery of any injury, including reasonable description of the particulars of said injury; (4) forward to the Fund any legal process received by the insured relating to any injury; (5) attend hearings and trials, assist in securing and giving evidence and in the conduct of suits or proceedings, at the Fund's request. The insured shall not voluntarily make any payment, assume any obligation or incur any expense other than for such immediate medical and other services at the time of injury as are necessary, or make any negotiation or settlement, except with the express consent of the Fund.

8. Duration of Policy and Cancellation.

This policy becomes effective upon the date shown in the Declarations, and remains in effect until cancellation by the insured or the Fund as provided herein.

Cancellation may be accomplished:

(a) By the insured. If the insured transfers coverage to another insurer or withdaws from business, this policy may be cancelled by notifying the Fund in writing, showing the last date upon which his employees worked, or the date on which the coverage transferred or the business ceased. Cancellation shall become effective upon the date of receipt of this information and documents, or the date on which coverage becomes effective with another carrier, whichever occurs first.

(b) By the Fund. The Fund may cancel this policy for nonsubmission of payroll reports, for nonpayment of premium, for failure to pay increased deposit when required, or for cause at any time by giving notice to the insured at least thirty (30) days prior to the effective date of such cancellation.

In the case of termination of this policy, refund of the initial deposit shall be made after application thereof to the unpaid premiums, provided at least $25 in premium has been paid by the insured during the policy period.

9. Assignment.

Assignment of interest under this policy shall not bind the Fund until its consent is indicated by endorsement. If, however, during the policy period the insured shall die, and written notice is given to the Fund within thirty (30) days after the date of such death, this policy shall cover the insured's legal representative as insured.

10. Subrogation.

In the case of any payment for compensation or medical services under this policy or assumption therefor, the Fund shall be subrogated to all rights of the insured against any person to the fullest amount of such payment or liability as provided by the workers' compensation laws of Montana.

11. Dividends.

The named insured shall be entitled to participate in the distribution of dividends to the extent and upon conditions fixed by the Fund.

12. Extraterritorial Coverage.

The insured agrees to notify the Fund in advance of any Montana employees it intends to employ temporarily outside of the State of Montana, and of any out-of-state employees it intends to employ temporarily in Montana.

IN WITNESS WHEREOF, the State Compensation Insurance Fund has caused this policy to be signed by the Supervisor of Policy Services.

Diana L. Power

STATE PUBLISHING CO., HELENA, MONT.