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Workers' Compensation Supplemental Application

(To be completed with Acord 130 Application)

Named Insured: ____ Insured's FEIN: __________________________________

Insured's Email Address: _________________________________ Web Address:____________________________________

CONTACT NAME & PHONE NUMBER

Inspections: ____ Phone: _____________________________________

Premium Audit: ____ Phone: _____________________________________

Claims: ____ Phone: _____________________________________

PRIOR PAYROLL & PREMIUM INFORMATION

	Total Annual Payroll	Premium $
Current Year: 20____		
Prior Year: 20____		
Prior Year: 20____		
Prior Year: 20____		
Prior Year: 20____		

OPERATIONS AND BENEFITS

Broker Controlled Account? ☐ Yes ☐ No

Please provide a detailed description of the operation: ____

____

Years in business: ________ Hours of Operation: ________ to _______ Number of Shifts: ________

Does the applicant ever allow employees to work more than 3 consecutive 12 hour shifts? ☐ Yes ☐ No

Is there a driving/delivery exposure? ☐ Yes ☐ No

If yes, what is the frequency? ☐ Daily ☐ Weekly ☐ Other: __________

Is a PUC/DMV filing required? ☐ PUC ☐ DMV ☐ N/A

Are vehicles company owed? ☐ Yes ☐ No

If yes, types of vehicles: ____

If yes, are vehicles taken home? ☐ Yes ☐ No

Number of vehicles: __________ Number of drivers: ___________

What is the radius of operations/travel: ☐ <50 miles ☐ 51-100 ☐ 101+

Is there any group transportation of employees? ☐ Yes ☐ No

If yes, how is it provided? ☐ Car ☐ Truck ☐ Van ☐ Bus

Number of employees transported per vehicle: _________ Number of vehicles used to transport: __________

Frequency: ☐ Daily ☐ Weekly ☐ Monthly

Is there a vehicle/fleet maintenance program? ☐ Yes ☐ No

If yes, who does the servicing? ☐ Outside vendor ☐ In-house mechanics ☐ Other: ______________

Do employees use personal vehicles for company business? ☐ Yes ☐ No

Do any employees work from home? ☐ Yes ☐ No

List the number of employees who live or work out of state: Live: ___________ Work: ___________

Any out of state, international, or overnight (within state) travel? ☐ Yes ☐ No

If yes, please provide the following details:

Why./Purpose: ____

Who will travel: ____

Where: ____

Duration: ______________________________ Frequency: ______________________________

Number of employees *(verify numbers are consistent with the number on Acord 130 Application)*:

Full-Time: __________ Part-Time: __________ Seasonal: _________ Volunteers: __________

Number of employees per location: *(If more space is needed please use separate page)*

Location #1: __________ Location #2: __________ Location #3: _________ Location #4: __________

Number of W2's issued: Last Year: _________ Previous Year: _________

How are employees paid? ☐ Hourly ☐ Piece Rate ☐ Commission ☐ Flat Salary ☐ Other: ______________

Are any day laborers or temporary/employees leasing? ☐ Yes ☐ No

If yes, please provide details on separate page.

Percentage of union employees: _________% If union, what is the expiration date of the contract? ______________

Percentage of Non-Union Employees: __________%

Is there paid sick leave? ☐ Yes ☐ No

Is there paid vacation? ☐ Yes ☐ No

What is the actual average hourly wage for employees in governing class: $_______/hour

Is there a Retirement/Pension plan? ☐ Yes ☐ No

If yes, does the employer contribute? ☐ Yes ☐ No

Is a group medical plan provided? ☐ Yes ☐ No

If yes, name of healthcare provider: ____

Percentage of employees enrolled: __________% Percentage paid by the employer: ___________%

Do you use a specific medical provider to treat injured employees? ☐ Yes ☐ No

Are you currently participating in a MPN (Medical Provider Network)? ☐ Yes ☐ No

If yes, please provide the name of the current MPN: ____

Is CPR training provided? ☐ Yes ☐ No

Number of employees certified? ______________

Is there a RTW program? ☐ Yes ☐ No

If yes, does it include salary continuation? ☐ Yes ☐ No

Has the ownership of the applicable entity changed within the past 5 years? ☐ Yes ☐ No

If yes, please provide details: ____

HIRING PRACTICES – EMPLOYEE SELECTION – CLAIMS

Written Application?	☐ Yes ☐ No	Pre-hire drug testing?	☐ Yes ☐ No
Reference Checks?	☐ Yes ☐ No	Post- accident drug testing?	☐ Yes ☐ No
Pre/Post employment physicals?	☐ Yes ☐ No	MVR Checks?	☐ Yes ☐ No
Orthopedic back testing?	☐ Yes ☐ No	Audio hearing tests?	☐ Yes ☐ No
Formal job descriptions on file?	☐ Yes ☐ No	Criminal background checks?	☐ Yes ☐ No
Are personnel files documented for pre-existing injuries?	☐ Yes ☐ No	Do you have a formal written accident report?	☐ Yes ☐ No
Average claim reporting time frame: ______________________		Are there set procedures for reporting claims?	☐ Yes ☐ No
Is job specific training provided?	☐ Yes ☐ No	Any interchange of labor?	☐ Yes ☐ No

		• If yes, please explain: ☐ Another business ☐ Subsidiary ☐ Between departments ☐ Other: ________________________
Employee Orientation Program? • If yes, is the orientation? ☐ Verbal ☐ Documented ☐ Both	☐ Yes ☐ No	Employee to Supervisor ratio: ☐ Better than 4-1 ☐ 5-1 ☐ 6-1 ☐ 7-1 ☐ >7-1
Subcontractor used? • If yes, for what purpose: ________________________ • If yes, are certificates of insurance obtained and kept on file? ☐ Yes ☐ No	☐ Yes ☐ No	
Independent contractors used? • If yes, for what purpose: ________________________ • If yes, how are they paid? ☐ 1099's ☐ Other (please explain): ________________	☐ Yes ☐ No	

SAFETY PROGRAM AND ORGANIZATION – WORK PREMISES AND ENVIRONMENT

Are owners active in daily operations?	☐ Yes ☐ No	• If yes, are they excluded from coverage?	☐ Yes ☐ No
Active injury & illness prevention program?	☐ Yes ☐ No	Has loss control services been performed in the last year?	☐ Yes ☐ No
Active safety incentive program? • What type of incentive: ____________________ ____	☐ Yes ☐ No	• If yes, does it encompass all employees?	☐ Yes ☐ No
Has Cal/OSHA visited or cited your business in the last year? *If yes, please provide explanation on separate page*	☐ Yes ☐ No	Are safety meetings conducted? • If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other: ______________	☐ Yes ☐ No
Do employees receive safety training/ orientation? • If yes, is the training: ☐ Formal / Documented ☐ Informal	☐ Yes ☐ No	Do you have a safety director or risk manager? • If yes, name & title: ____________ ____________________________ • If yes, is the position full-time or and additional responsibility of another employee?	☐ Yes ☐ No ☐ Full-time ☐ Additional responsibility
MSDS (Material Safety Data Sheets) available for all chemicals and products used? ☐ N/A	☐ Yes ☐ No	Any material handling exposures? • If yes, please explain: ____________________________ ____________________________ ____________________________	☐ Yes ☐ No
Any lifting exposures? ☐ N/A • If yes, what is the weight? • If 41+ lbs., manual lifting or with assistance? Please explain: _________________________ _________________________	☐ Yes ☐ No ☐ <25 lbs. ☐ 26-40 lbs. ☐ 41+ lbs.	Forklift training provided? ☐ N/A • If yes, annual certification?	☐ Yes ☐ No ☐ Yes ☐ No
Is all machinery/equipment properly guarded? ☐ N/A	☐ Yes ☐ No	Any use of Baler equipment?	☐ Yes ☐ No
Written lock out/ tag out/ block out procedures in place? ☐ N/A	☐ Yes ☐ No	Condition of equipment: ☐ New ☐ Good ☐ Average	
Respiratory program in place? ☐ N/A	☐ Yes ☐ No	Are all equipment operators trained/ certified?	☐ Yes ☐ No

What is the maximum height at which you will work? ___________________________ • What is used? ☐ Ladder ☐ Scaffolding ☐ Scissor lifts ☐ N/A	Personal protection equipment provided? • If yes, strict enforcement of utilization? • What types of PPE are used: ___________________________ ___________________________	☐ Yes ☐ No ☐ Yes ☐ No

HEALTHCARE

☐ For Profit	☐ Hospital Affiliation: ___________________________	
☐ Not for Profit	☐ Religious Affiliation: ___________________________	
☐ Medicare Certified	☐ JCAHO Accredited (date): ___________________________	
☐ Medicaid Certified	☐ Government	
	% of residents	**Separate Unit?**
Psychiatric Care (excluding depression)	____________%	____________
Dementia/Alzheimer	____________%	____________
Mental Retardation	____________%	____________
HIV (AIDS)	____________%	____________
Other: ___________________________		
% of Ambulatory without assistance: ____________%		
Please explain any changes during the last 3 years; or anticipated changes in the next year: ___________________________		

Does your IIPP (SB198) address the following specific healthcare related exposures:		
Patient Handling?	☐ Yes ☐ No	Comment: ___________________________
Blood-borne pathogens?	☐ Yes ☐ No	Comment: ___________________________
Aggressive/Combative behaviors?	☐ Yes ☐ No	Comment: ___________________________
Other: ___________________________	☐ Yes ☐ No	Comment: ___________________________

Is a registered nurse, manager, or supervisor who knows procedures for Workers' Compensation and Safety on each shift? • If yes, please describe: ___________________________	☐ Yes ☐ No
Do you treat any worker injuries on site? • If yes, please describe: ___________________________	☐ Yes ☐ No
Are all injuries reported to your insurer? • If NO, please explain: ___________________________	☐ Yes ☐ No
Do you have a policy to maintain contact with an injured worker?	☐ Yes ☐ No
For Skilled Nursing Facilities only, please answer the following: Within the past year has there been a change in the Administrator or Director of Nursing positions? • If yes, please explain: ___________________________ ___________________________	☐ Yes ☐ No
% of turnover of RN/LVN positions during the last year: ____________%	
Percentage of new residents that you evaluate prior to admission: ____________%	

Note: All information provided is subject to verification by way of an underwriting survey or inspection. We must be notified of any significant change in operation or payroll. Terms of insurance coverage may be canceled for misrepresentation if information provided is inaccurate.

Signature of Applicant: ___________________________ Date: ____________________