



RT WC Specialty

**Group Home & Social Service Product
Supplemental Application**

Insured Name: _____

Insured Web Address: _____

Insured FEIN: _____

Payroll/Premium Information:

<u>Policy Year</u>	<u>Payroll</u>	<u>Premium</u>
4th Prior	\$	\$
3rd Prior	\$	\$
2nd Prior	\$	\$
1st Prior	\$	\$
Current	\$	\$

Business Operations

Please provide a detailed description of the operation:

List the Applicant's State of Operation:

- For Profit
 Not for Profit
 Partnership
 Other

If other, please specify : _____

1. Are medical/health insurance benefits provided to employees? Yes No
2. Are at least 60% of the insured's staff professional employees? Yes No
3. Is 24-hour staffing provided? Yes No
4. Indicate percentage of volunteers in the workforce:
 0%
 1 – 10%
 11 – 40%
 >40%
5. Does the Insured have a Residential Housing Facility? Yes No
6. Does the Insured have a formal safety program? Yes No
7. Does the insured complete drug testing prior to employment and post accident? Yes No

8. Does the insured complete a criminal background check? Yes No

9. Does the insured complete a child abuse clearance check? Yes No

Business Operations (Check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Mental Health Counseling | <input type="checkbox"/> Substance Abuse Counseling | <input type="checkbox"/> Residential/Group Homes |
| <input type="checkbox"/> Foster Care Provider | <input type="checkbox"/> Secured/Lockdown Facilities | <input type="checkbox"/> Shelters |
| <input type="checkbox"/> Vocational Training/Programs | <input type="checkbox"/> Crisis Response Team | <input type="checkbox"/> Adult Day Care |
| <input type="checkbox"/> Physical/Occ. Health Therapy | <input type="checkbox"/> Drug Treatment/Detox | <input type="checkbox"/> Health Clinics |

Please indicate where your employees perform their work:

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Private Homes/Apartment | <input type="checkbox"/> Clinics | <input type="checkbox"/> Group Homes |
| <input type="checkbox"/> Shelters | <input type="checkbox"/> Hospitals | <input type="checkbox"/> Corporate Offices |
| <input type="checkbox"/> Day Care Setting | <input type="checkbox"/> Job Coaching | <input type="checkbox"/> Other Locations |

If other, please specify: _____

**** The undersigned attests that all information provided is both accurate and truthful. All information provided is subject to verification by way of an underwriting survey or inspection. You must notify RT Specialty of any significant change in operations or payroll. Terms of insurance coverage may be canceled for misrepresentation if information provided is inaccurate.****

Signature of Applicant: _____

Title: _____

Print Name: _____ Date: _____