Workers Compensation Supplemental Application

Account Information	
Named Insured:	
Federal Employer ID No.:	
Website:	
Contact Name/Number:	
Prior Premium Information	
Current Year:	
Prior Year:	
Prior Year:	
Prior Year:	
Prior Year:	
Prior Payroll Information	
Current Year:	
Prior Year:	
Prior Year:	
Prior Year:	
Prior Year:	

Operations and Benefits	
Detailed Description of Operations:	
Hours of Operation and Number of Shifts:	
Driving or Delivery Mileage:	☐ <50 ☐ 51-100 ☐ 101+ ☐ No Driving Exposures

Group Transportation (more than 4 employees):	☐ No ☐ Yes
Are vehicles company owned:	☐ No ☐ Yes
Vehicle Maintenance Program:	☐ No ☐ Yes
If so, by who:	☐ Outside Vendor ☐ In-House Mechanics ☐ Other
Overnight travel by employees:	☐ No ☐ Yes
If so, frequency:	
Full Time Employees:	
Part Time Employees:	
Seasonal Employees:	
Union Employees:	☐ No ☐ Yes
How are employees paid:	☐ Hourly ☐ Piece rate ☐Commission ☐ Salary ☐ Other (please explain):
Average Hourly Wage:	$
Paid Sick Time:	☐ No ☐ Yes
Paid Vacation:	☐ No ☐ Yes
Retirement/401k:	☐ No ☐ Yes
Group Health Coverage:	☐ No ☐ Yes If yes, what percentage is paid by the employer: %

Hiring Practices	
Written Application:	☐ No ☐ Yes
Reference Checks:	☐ No ☐ Yes
Physicals:	☐ No ☐ Yes
Pre-hire drug testing:	☐ No ☐ Yes
Post-accident drug testing:	☐ No ☐ Yes
MVR Checks	☐ No ☐ Yes
Criminal Background Checks:	☐ No ☐ Yes
Documentation of pre-existing injuries:	☐ No ☐ Yes

Return-To-Work/Light Duty Available:	☐ No ☐ Yes
Subcontractors Used:	☐ No ☐ Yes If yes, what % of payroll is assigned to subs: %
Are certificates of insurance obtained for subs:	☐ No ☐ Yes
Independent Contractors Used:	☐ No ☐ Yes

Safety Program and Organization	
Safety Program in Place:	☐ No ☐ Yes If yes: ☐ Formal/Written ☐ Informal/Verbal
Safety Incentive:	☐ No ☐ Yes
Safety Training:	☐ No ☐ Yes If yes, is the training: ☐ Documented or ☐ Verbal
Safety Meetings:	☐ No ☐ Yes If yes, frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other:
MSDS Program:	☐ No ☐ Yes
Lifting Exposures:	☐ No ☐ Yes If yes, ☐ <25lbs ☐ 25-40 ☐ 40+ lbs
Machinery Guarded:	☐ No ☐ Yes
Lockout/Tagout:	☐ No ☐ Yes
Forklifts:	☐ No ☐ Yes If yes, annual certifications: ☐ No ☐ Yes
Respiratory Program	☐ No ☐ Yes ☐ N/A If yes, what type:
Maximum Height in Feet:	ft.
If heights, what is used:	☐ Ladder ☐ Scaffolding ☐ Scissor Lifts ☐ Other:
Personal protective equipment:	☐ No ☐ N/A ☐ Goggles ☐ Gloves ☐ Non-Slip Shoes ☐ Steel Toed Boots ☐ Hard Hats ☐ Masks ☐ Back Belts ☐ Protective Clothing ☐ Other:

Healthcare	
Business Operations (check all that apply):	☐ Ambulance Services ☐ Group Home ☐ Hospital ☐ Mental Health ☐ Rehab Clinic ☐ School for Challenged ☐ Visiting Nurse Services ☐ Assisted Living Center ☐ Healthcare Staffing ☐ Medical Equipment Provider ☐ Nursing Home/Long Term Care ☐ Retirement Home ☐ Substance Abuse Counseling ☐ Community Organization ☐ Home Care Services ☐ Medical Services ☐ Physical Therapy/Occu Health ☐ Social Service Organization ☐ Women's Shelter ☐ Other:
Total Number of Beds (if applicable and per location):	
Lifting Program:	☐ No manual lifting allowed: <u>All</u> lifting done with mechanical devices. List devices: ☐ Minimal manual lifting. Most lifting done with mechanical devices. (Situations requiring manual lift utilize 2+ staff, lifts, gait belts, slide sheets, etc.). List devices: ☐ No Formal lifting program in effect. ☐ Not applicable – no patient handling performed by this applicant.
Slip and Fall Program:	Please describe in detail:
Home Health Care:	% Skilled Services – RNs performing wound care, injections, and prescription management. % Unskilled Services – All others.

Owner/Officer: _____ **Date:** ____/____/____