

Workers' Compensation Supplemental Application

Insured: _____ Eff Date: _____

DBA: _____

Market Selection:

State Fund of CA

AmTrust

Everest National

Hartford

Travelers

Employers

Guard

ICW

Zenith

First Comp

Section 1: No Prior Insurance and New Ventures

1. Reason for no prior insurance - select one answer:

- Commencing to do business for the first time.
- Operating without employees and now hiring for the first time.
- Operating with employees without WC coverage.
- Other: _____

2. Date employees began working or will begin working for applicant: _____

Section 2: Payroll and Premium History - all policies held within the last 4 years

Payroll :	Expiring Yr. _____	Premium:	Expiring Yr. _____
	1st Prior Yr. _____		1st Prior Yr. _____
	2nd Prior Yr. _____		2nd Prior Yr. _____
	3rd Prior Yr. _____		3rd Prior Yr. _____

Section 3: Bankruptcy

1. Business or any principal of the business declared bankruptcy in the last seven years: Yes No

If Yes, please provide:

Name of Principal: _____ Chapter of Bankruptcy: _____
 Date Filed: _____ Case Number: _____ Status: _____
 Court Where Case Was Filed: _____

Section 4: Licenses

1. Contractors State License Board

CSLB Number: _____ or CSLB App Number: _____

2. Farm Labor Contractor License

Farm Labor Contractor? Yes No

If yes, please provide Farm Labor Contractor License Number: _____

3. Transportation Licenses - complete sections 10 & 11

USDOT Number: _____ DMV/MCP Number: _____

PUC Number: _____ Permit Type: _____

4. Other License Information

Other License Information: _____

Section 5: Additional General Questions

1. Offer the majority of your eligible employees Health Insurance: Yes No

If no, who is eligible: _____

If yes, Health Insurance Carrier: _____

	% paid by employer	%	% of participation
Group Health <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

2. Obtain workers from a professional employer organization (PEO), employee leasing firm, labor contractor, or any third-party entity: Yes No

3. Obtain temporary workers from other employers: Yes No

4. Assign temporary laborers to your current or potential clients: Yes No

5. Assign leased or long-term workers to your current or potential clients: Yes No

Section 6: Additional Questions

- 1. Use any equipment that bends, forms, shapes, or cuts materials (e.g., power press): Yes No
- 2. Employ any relatives: Yes No
- 3. Employ any minors (under age 18): Yes No
- 4. Make any cash payments to employees or subcontractors: Yes No
- 5. Provide meals or lodging in lieu of wages: Yes No
- 6. Pay any employees by the piece: Yes No
- 7. Have any work at a maritime or offshore facility: Yes No
- 8. Have any locations/operations for which coverage is not required: Yes No
- 9. Have any operations outside of California: Yes No
- 10. Perform any asbestos removal: Yes No
- 11. Member of any trade or business association: Yes No

Please explain any answers marked yes: _____

Section 7: Management Practices Questions

- 1. Employee assistance program: Yes No
- 2. Paid vacations: Yes No
- 3. Paid sick leave: Yes No
- 4. Injury and illness prevention program in place: Yes No
- 5. Written return to work program for employees injured on the job: Yes No
- 6. Document employee training: Yes No
- 7. Document facility inspections: Yes No
- 8. OSHA citations within the past year: Yes No

If yes, please explain: _____

- 9. Provide temporary workers to other employers: Yes No

If yes, please explain: _____

- 10. Check off the hiring practices implemented by your company:

- | | |
|--|--|
| <input type="checkbox"/> Job descriptions | <input type="checkbox"/> Employment application |
| <input type="checkbox"/> Pre-placement medical screening | <input type="checkbox"/> Motor Vehicle Record check |
| <input type="checkbox"/> Pre-placement drug screening | <input type="checkbox"/> Audiometric testing |
| <input type="checkbox"/> Drug-free workplace | <input type="checkbox"/> Pathogenic test (i.e. lead) |
| <input type="checkbox"/> Pre-employment reference checks | <input type="checkbox"/> Orthopedic back test |
| <input type="checkbox"/> Union employees | |

- 11. Indicate the safety activities currently established and practiced regularly:

- Return to light duty plan
- Return to Full-time modified work plan
- Designated Full-time safety director
- Safety meetings held for all employees
- Safety training held for all employees
- Personal protective safety equipment provided for all employees

Includes full wages: Yes No

Name: _____

Frequency of meetings: _____

If yes, what equipment is provided: _____

- Supervisors are held accountable for injuries / accidents
- Accident investigation program in place

Section 8: Prior State Fund Policies

- 1. Has the business been insured by State Fund: Yes No
- If yes, please answer the following:
- Name of entity and/or individual that is or was insured with State Fund: _____
- Most recent policy number: _____ Coverage Dates: _____ From: _____ To: _____

Section 9: Purchase Acquisition

1. Was this operation all or part of an existing business that was purchased or acquired: Yes No

If yes, please answer the following:

Percentage of business acquired: _____% Date ownership changed: _____
 _____ Prior business

owner's name: _____
 _____ Prior business

address: _____

Prior name of business: _____

Is prior owner related to the new owner: Yes No If yes, list relationship below

Have operations changed since business acquired: Yes No

Percentage of employees kept from previous owner: _____%

Are those employees earning more than 50% of the payroll: Yes No

Additional comments: _____

Section 10: Automobiles

Business operations include driving by employees for the following purpose(s):

1. Delivery: Yes No Frequency of delivery: Daily Weekly Other: _____

Delivery radius: <50 Miles 51-100 Miles 101-250 Miles >250 Miles

2. Travel to or between jobsites/facility locations: Yes No If yes, Frequency: _____ Radius: _____

3. Group transportation of employees: Yes No If yes, indicate max # employees per vehicle: _____

4. Sales/Service Calls: Yes No If yes, Frequency: _____ Radius: _____

5. # of authorized drivers: _____ # of company vehicles: _____ # of employee-owned vehicles used in business: _____

6. Frequency of MVR checks: _____ Participation in CHP Pull program: Yes No

7. Driver acceptability standards have been established: Yes No

8. Vehicles inspection / maintenance program: Yes No Frequency: _____

9. Vehicle maintenance is performed by employees: Yes No

10. Employees take company vehicles home at night: Yes No

Section 11: Industry Specific Questions

Apartment Owner or Operator

Total # of Units: _____ Units Per Each Location: _____

Total # of maintenance employees: _____ Typical duties: _____

Swimming Pool: Yes No If Yes, does pool have: Fence Self-latching Gate Rules Posted Accessible Life-Safety Equipment

Do employees perform any of the following types of work?

At heights over 12 feet: Yes No If yes, explain: _____

Extermination or fumigation: Yes No If yes, explain: _____

Furnace cleaning: Yes No If yes, explain: _____

Any work subcontracted: Yes No If yes, complete "Sub-Contracted Work" Section of this app

Attorneys

What type of law: _____

Any criminal law: Yes No Any insurance law: Yes No

Contractors (Complete this section for any risk performing contracting, service/repair or installation work)

Annual Gross Receipts: _____

General description of work done: _____ Yes No

Indicate % of work in each of the following operations:(each line must equal 100%)

New Construction: Residential _____% Commercial _____% Industrial _____%

Remodeling: Residential _____% Commercial _____% Industrial _____%

Service/Repair: Residential _____% Commercial _____% Industrial _____%

Installation: Residential _____% Commercial _____% Industrial _____%

Interior work _____% Exterior Work _____% Max height of work: _____

Equipment Used: Cranes/Booms Heavy Equipment Excavation Equipment Scaffolds Ladders Other

If any of the above used, describe: _____

Any work subcontracted: Yes No

If yes, complete "Sub-Contracted Work" section below

Sub-Contracted Work

List each operation sub-contracted to others: _____

Annual Subcontracted Cost (labor & materials): _____

The following items are maintained and kept current for all sub-contractors:

Certificate of workers' compensation insurance Yes No

Certificate of general liability insurance with like limits and additional insured status: Yes No

Copy of each sub-contractor's license number Yes No

List below current sub-contractors, including contractor's license numbers: (If more than 3 provide a separate list)

Landscaping or Lawn Service

Annual Gross Receipts: _____

Any use of pesticides/herbicides: Yes No If yes, explain: _____

Tree Trimming: Yes No If yes, % of total operations: _____ Work performed: from heights from ground

If tree trimming work from heights, describe: _____

Work along highways or freeways (including on/off ramps) or conducting traffic diversion: Yes No

If yes, explain: _____

Trenching operations and/or work below depth of 4 feet: Yes No

If yes, explain: _____

Hotel/Motel

Annual Gross Receipts: _____

Food service: Operate own: Yes No Subcontract: Restaurant Bar Both

Gross receipts: Food _____ % Alcohol _____ %

Entertainment: Yes No Lounge Armed Security

Operations: Year Round Seasonal Conference Center

Shuttle service: Yes No How many vans: _____

How are maids compensated: Salary Hourly Wage Flat Rate Per Room

Who flips the mattresses and how are they turned: _____

Restaurants/Bars

Annual Gross Receipts: _____ Catering: Yes No % of Revenue: _____

Alcohol Receipts (% of gross receipts): _____ Delivery: Yes No % of Revenue: _____

Average Entrée Price: _____ If yes, radius of delivery area: _____

Hours of operation: _____ to _____ Number of Daily Shifts: _____

Number of: Hosts _____ Wait-staff _____ Cooks _____ Bartenders _____ Valet Parkers _____ Security _____

Entertainment: Yes No Dance floor: Yes No Square Ft: _____

If yes, describe? _____

Food truck: Yes No

Manufacturing

Annual Gross Receipts: _____

Product Description: _____

Hours of operation: _____ to _____ Number of Daily Shifts: _____

Lock-out/Tag-out program in place: Yes No

Machine guarding: Point of operation: Yes No Drive mechanism: Yes No Moving Parts: Yes No

Type of Machines Used? _____

Material handling exposure: Yes No Lifting: Below 50 lbs. Above 50 lbs. _____

Off premises operations: Yes No Percentage: _____ Where / What: _____

Retail/Wholesale

Annual Gross Receipts: _____ Wholesale: _____ % Retail: _____ %
 Type of merchandise: _____ Hours of operation: Import Domestic
 _____ to _____ Number of Daily Shifts: _____
 Employee Compensation: Flat Salary Hourly Wage Commission
 Outside sales employees: Yes No Is there assembly: Yes No
 Lifting exposure or repackaging: Yes No Lbs.: _____ Installation of product at customer premises: Yes No

Service Stations/Auto Repair Shops/Transmission Shops

Annual Gross Receipts: _____
 Hours of operation: _____ to _____ Mini-Market: Yes No Alcohol sold: Yes No
 Gas operation: Full Service Self Service Yes Bullet proof cashier booth: Yes No
 Repair operation: No Drop safe or registers: Yes No
 Tire Repair/Installation Over 1-Ton Truck Car Wash: Yes No If yes, Self Serve Full Serve
 Towing: Yes No Contract tow: Yes No Access to freeway: 0-1 mile 1-2 mile 2+ mile

Trucking & Couriers/Parcel Delivery

Annual Gross Receipts: _____
 Does business have any 1099 Employees: Yes No
 If yes, Number of 1099's: _____ and Payroll: _____ Is this pay included in Acord payroll: Yes No
 Please indicate the operations of the business: Interstate Intrastate
 Type of goods delivered: _____

SIGNATURE

TO BE COMPLETED BY BROKER, OWNER, OR AN OFFICER/PARTNER OF THE BUSINESS OF THE BUSINESS SEEKING COVERAGE

Insurance Code Article 6, Sec.11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. All insurance carriers reserve the right to verify the accuracy of information provided to them by insurance applicants. I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge.

Completed by: _____ Title: _____
 Signature: _____ Date: _____

Breakdown of Payroll by Classification

Class Code	Description	# of Employees	Annual Payroll