

**WORKERS COMPENSATION SUPPLEMENTAL APPLICATION**

NAMED INSURED \_\_\_\_\_ Policy Effective Date \_\_\_\_\_

OWNERS:       Active  Absentee       Delegate through supervisors  
 Years in Business \_\_\_\_\_ Years of Experience – same industry: \_\_\_\_\_  
 Other currently owned businesses which are separately insured?  Yes  No  
 If yes, identify these entities and explain any interchange of labor with these different affiliates: \_\_\_\_\_

OPERATIONS:      Hours of Operation: \_\_\_\_\_ to \_\_\_\_\_      Number of days per week: \_\_\_\_\_

Overtime:  None     Occasionally     Often

Percentage of work subcontracted: \_\_\_\_\_ %    Type of work subcontracted: \_\_\_\_\_

Are Certificates of Insurance, evidencing WC coverage, required and obtained from all subcontractors?  Yes  No

Describe any other physical or contractual controls in place over subcontractors: \_\_\_\_\_

Do you lease workers?  Yes     No

If yes, describe type of labor leased and identify leasing company: \_\_\_\_\_

Who is responsible to provide Workers Compensation coverage to leased workers?  Leasing Co.  You

Do you lease workers to others?  Yes     No    If yes, explain: \_\_\_\_\_

If yes, who is responsible to provide Workers Compensation coverage to leased workers?  Client Co.  You

**Vehicle and Driving Exposure:**

Identify number of company vehicles \_\_\_ PPTs \_\_\_ P/Us \_\_\_ Med. & Heavy Trucks \_\_\_ Tractors \_\_\_\_\_

Number of regular drivers of company vehicles: \_\_\_\_\_

Number of employees who regularly drive their own vehicles on company business: \_\_\_\_\_

Percent of travel that exceeds a 150 mile radius? \_\_\_\_\_ %

Are Motor Vehicle Records (MVRs) checked on all company drivers?  Yes  No

If No, explain: \_\_\_\_\_

Total number of employees: Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Seasonal: \_\_\_\_\_ Union?  Yes  No

Governing Classification Wages: Starting: \$ \_\_\_\_\_ Average: \$ \_\_\_\_\_

Estimated % of employees the Insured has employed for less than one year: \_\_\_\_\_ %

Any employees in a monopolistic state (ND, OH, WA, WV, WY)?  Yes  No Which State(s)? \_\_\_\_\_

If yes, how many employees are in these states? \_\_\_\_\_

Do job duties include travel outside the United States?  Yes  No If yes, describe:

# of employees who travel overseas each year \_\_\_\_\_

Average frequency of travel each year for those employees who travel overseas \_\_\_\_\_

Average duration of trips overseas \_\_\_\_\_

Identify countries involved \_\_\_\_\_

Does Insured have employees exposed to any of the following types of operations or activities:

Commercial delivery of letters or packages     Food or Beverage processing or packaging     Water Treatment Plants

Please Explain: \_\_\_\_\_

**PAYROLL INFORMATION:**

<u>Policy Term</u>	<u>Total Payroll</u>	<u>Total Premium</u>	<u>Audited Payroll</u>
2002/2003 estimated	\$ _____	-----	-----
2001/2002 expiring yr.	\$ _____	\$ _____	-----
2000/2001	\$ _____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1999/2000	\$ _____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1998/1999	\$ _____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1997/1998	\$ _____	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**HIRING AND EMPLOYMENT PRACTICES:**

Pre-Hire Physicals  Yes  No Complete Application  Yes  No  
Post-Hire Physicals  Yes  No References Checked  Yes  No  
Pre-Hire Drug Screen  Yes  No Random Drug Testing  Yes  No  
Drug/Alcohol Rehab Program  Yes  No Return to Work Program  Yes  No  
Written Personnel Procedures  Yes  No

**BENEFITS:**

Group Medical:  Yes  No Eligible employees:  Full Time only  All employees, including Part Time  
Percent Paid by Employer: \_\_\_\_\_%

Disability Insurance provided?  Yes  No Paid sick days?  Yes  No  
Other Benefit Programs: \_\_\_\_\_

**WORKERS COMPENSATION MEDICAL PROVIDER:**

Clinic  Physician  Emergency Room

Does the Insured use a specific medical provider or network to treat injured employees?  Yes  No  
If yes, please identify the provider or network: \_\_\_\_\_

**LOSS CONTROL AND SAFETY**

Risk Manager  Yes  No  Full Time  Part Time  
Safety Director  Yes  No  Full Time  Part Time

Name and title of person(s) responsible for safety: \_\_\_\_\_

Written Safety Program?  Yes  No  
Safety Incentive Program?  Yes  No Is compensation to supervisors adjusted based on safety record?  Yes  No

Does the Insured require immediate Loss Control or Engineering services?  Yes  No  
Is Insured willing to implement loss control recommendations made by the insurer?  Yes  No  
Are supervisors trained in safety education?  Yes  No If yes, how frequently? \_\_\_\_\_  
Safety meetings held regularly with employees?  Yes  No If so, how often?  
 Weekly  Monthly  Quarterly.  Semi-Annual  
Accident review program?  Yes  No Hazard identification training?  Yes  No  
Hazardous Materials Communication program in place?  Yes  No  
Describe equipment used:  State of Art  Standard for Industry  Modified to Standard  
Equipment inspection/maintenance program?  Yes  No If yes, describe: \_\_\_\_\_  
Any ergonomic concerns with your equipment or machinery now or in the past?  Yes  No If yes, please describe:

Machine guarding exposure:  All Properly Guarded  Partially Guarded\*  Minimal/No Guarding \*  
\*Describe machinery or equipment lacking guarding: \_\_\_\_\_

Lock Out/Tag Out program in place?  Yes  No  
Personal Protective Equipment:  Required  Recommended  Not Required or Recommended  
Describe personal protective equipment used: \_\_\_\_\_  
Lifting Exposure:  Less than 10 pounds  11 to 40 lbs.  40 to 60 lbs.  Over 60 lbs.  
Describe lifting and any mechanical aids: \_\_\_\_\_  
Formal safe lifting training or program ?  Yes  No

Does Insured conduct periodic Fire and Emergency Evacuation drills?  Yes  No  
During these drills does the insured account for all employees  Yes  No  
Has Insured reviewed US Postal Service guidelines for handling suspicious mail and packages?  Yes  No  
Violence Intervention program?  Yes  No  
Drug/Alcohol awareness program?  Yes  No  
Any premises or jobsite security provided?  Yes  No If yes, please describe: \_\_\_\_\_

**CATASTROPHE EXPOSURE INFORMATION**

Identify all annual or regular business meetings, trade shows, conventions, training or other company events where 10 or more employees attend:

Type of Meeting, Location and Date	City	State	Zip Code	Number of Employees Attending

Does Insured have employees (10 or more) regularly working in close proximity (within 2 miles) to any of the following types of buildings or facilities (check all that apply):

<input type="checkbox"/> Government or Military Installations	<input type="checkbox"/> Specialized Industries supporting the Military	<input type="checkbox"/> Manufacturers of environmentally sensitive products
<input type="checkbox"/> Large Financial Institutions including national and regional stock exchanges	<input type="checkbox"/> Major Bridges, Tunnels, or Dams	<input type="checkbox"/> Transportation Hubs-Railroads, Airports, or Shipping
<input type="checkbox"/> Communication Centers: Major Network Radio and Television and Voice and Data Centers	<input type="checkbox"/> Utilities or Power Generation Plants	<input type="checkbox"/> Bulk Storage facilities (tank farms)
<input type="checkbox"/> Sport Stadiums/Arenas and Theme Parks	<input type="checkbox"/> Large Colleges, Universities or Schools	<input type="checkbox"/> Large Shopping Malls
<input type="checkbox"/> Historic/Symbolic buildings monuments, or parks	<input type="checkbox"/> Explosives manufacturing, distribution or storage	<input type="checkbox"/> Chemical manufacturing including pesticide, herbicide, or insecticide

Please provide the Insured’s street addresses where 10 or more employees work within close proximity to any of the above identified buildings or facilities: \_\_\_\_\_

**LOCATION/EXPOSURE INFORMATION – Attach extra copies of the following tables, if needed to identify all of the Insured’s locations and employee exposures**

**LOCATIONS (Actual street locations where operations are conducted, not mailing addresses)**

Location #	Street, City, State, Zip Code
01	
02	
03	
04	
05	
06	
07	
08	
09	
10	
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12	
13	
14	
15	



