SUPPLEMENTAL APPLICATION

Insured: _____ Eff Date: _____ FEIN NO. _____
Contact Name & Title: _____ Tel. #.: _____ Fax #.: _____ Website Address : _____

INSURED HISTORY:

Years in business: _____ No of locations _____
Description of operations _____
Present number of employees: Full time employees _____ Part time _____ Seasonal _____ Volunteers_____
Percent of employee turnover in the past last 12 months Full time _____ Part time _____
Employee staffing expectation over the next 12 months Full time _____ Part time _____
Average hourly wage: Full time $_____ Part time $_____
BENEFIT PROVIDED – are ALL employees eligible Y/N, if no then who?_____

			% paid by employer	**% of participation**
Group Health	☐ Yes	☐ No	_____	_____
Paid sick leave	☐ Yes	☐ No	_____	_____
Vacation	☐ Yes	☐ No	_____	_____
Retirement / Pension Plan	☐ Yes	☐ No	_____	_____

Name of Healthcare provider: _____
Do you use a specific: clinic _____ physician _____ emergency room _____
Full time nurse maintained on staff: ☐ Yes ☐ No
CPR training provided ☐ Yes ☐ No
Would you be willing to participate in the HCO program to control claim costs? ☐ Yes ☐ No

Indicate the safety activities currently established and practiced regularly:
Safety program / IIPP complaint with SB 198 ☐ Yes ☐ No
Return to light duty plan ☐ Yes ☐ No
Return to full time modified work plan ☐ Yes ☐ No
Designated full time safety director ☐ Yes ☐ No Name: _____
Safety meetings held for all employees ☐ Yes ☐ No Frequency of meetings _____
Safety training held for all employees ☐ Yes ☐ No Incentive program for employees ☐ Yes ☐ No
Personal protective safety equipment provided ☐ Yes ☐ No
Supervisors are held accountable for injuries / accidents ☐ Yes ☐ No
Accident investigation program in place ☐ Yes ☐ No

HIRING PRACTICES:

Employment application	☐ Yes	☐ No	Drug/substance abuse	☐ Yes	☐ No
Reference checks	☐ Yes	☐ No	Audiometric Testing	☐ Yes	☐ No
Motor Vehicle Record Check	☐ Yes	☐ No	Pre/Post employment physical	☐ Yes	☐ No
Volunteer Labor used	☐ Yes	☐ No	Pathogenic test (i.e. lead)	☐ Yes	☐ No
Temporary labor used	☐ Yes	☐ No	Orthopedic back test	☐ Yes	☐ No

OPERATIONS:

Hours of operation: _____ to _____ Number of daily shifts: _____
Operation includes delivery ☐ Yes ☐ No Number of authorized drivers _____ No. of vehicles _____
Frequency of delivery: Daily ☐ Weekly ☐ Other ☐ _____
Delivery radius: < 50 miles ☐ 51-100 miles ☐ 101-250 miles ☐ >250 miles ☐
Frequency of MVR checks _____ Participation in CHP Pull program ☐ Yes ☐ No
Driver acceptability standards have been established ☐ Yes ☐ No
Vehicles inspection / maintenance program ☐ Yes ☐ No Frequency _____
Vehicle maintenance performed is performed by employees ☐ Yes ☐ No
Employees take vehicles home ☐ Yes ☐ No

PAYROLL AND PREMIUM HISTORY:

Payroll : Current Year	_____	Premium: _____
1st	_____	_____
2nd	_____	_____
3rd	_____	_____

ANY TRAVEL OUT OF STATE OR COUNTRY ☐ Yes ☐ No NO. OF TRAVELING _____
FREQUENCY_____
PURPOSE:

HOTEL / MOTEL:

Number of guest rooms: _____ Room rate: Under $50 ☐ $50-74.95 ☐ $75-99 ☐ Over $100 ☐
Food service: Operate own: ☐ Yes ☐ No Subcontract: Restaurant ☐ Bar ☐ Both ☐
Gross receipts: Food _____% Liquor _____%
Entertainment: ☐ Yes ☐ No Lounge: ☐ Yes ☐ No Armed Security: ☐ Yes ☐ No
Operation: Year round ☐ Seasonal ☐ Conference center: ☐ Yes ☐ No
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: _____

RETAIL / WHOLESALE:

Gross receipts: Wholesale _____% Retail _____%
Type of merchandise: _____
Palletized: ☐ Yes ☐ No
Lifting exposure or repackaging: ☐ Yes ☐ No Lbs: _____
Compensation: Flat salary _____ Hourly wage _____
Commission _____
Outside sales employees: ☐ Yes ☐ No
Is there assembly: ☐ Yes ☐ No *If yes,* what? _____
_____

MANUFACTURING & ASSEMBLING:

Machine guarding: Point of operation: ☐ Yes ☐ No
Drive mechanism: ☐ Yes ☐ No
Moving Parts: ☐Yes ☐ No Lock out/tagout: ☐ Yes ☐No
% of – Point of operation guarding: _____
Moving parts _____ Drive Mechanism: _____
Material handling exposure: ☐ Yes ☐ No
Lifting: ☐ Below 50 lbs. ☐ Above 50 lbs. _____
Off premises operations: ☐ Yes ☐ No Percentage _____
Where / What: _____
Personal Protection equipment provided? ☐ Yes ☐ No
Use enforced? ☐ Yes ☐ No
TYPE OF MACHINES USED? _____

SERVICE STATIONS / AUTO REPAIR SHOPS / TRANSMISSION SHOPS:

Hours of Operation _____
Gas operation: ☐ Full Service ☐ Self service
Repair operation: ☐ Full Service ☐ Self service
☐ Tire repair/installation ☐ Over 1-ton truck (yes/no)
Towing: ☐ Yes ☐ No Contract tow: ☐ Yes ☐ No
Road Repair: ☐ Yes ☐ No
Frequency: Daily_____ Weekly_____ Monthly _____
Mini-Market: ☐ Yes ☐ No Liquor sold? ☐ Yes ☐ No
Bullet proof cashier booth: ☐ Yes ☐ No
Drop safe or registers: ☐ Yes ☐ No
Car Wash: ☐ Yes ☐ No *If yes,* ☐ self serve ☐ full serve
Access to freeway: ☐ 0-1 mile ☐ 1-2 miles ☐ 2+ miles
Saw guarding: ☐ Yes ☐ No

ATTORNEYS

What type of law: _____
Any criminal law: ☐ Yes ☐ No _____ Percentage Any insurance law: ☐ Yes ☐ No _____ Percentage

RESTAURANT:

Average Entrée Price: _____
Liquor Receipts (% of gross receipts) _____
Entertainment: ☐ Yes ☐ No If yes, please provide details:
_____
Catering: ☐ Yes ☐ No % of revenues: _____
Radius: _____
Delivery: ☐ Yes ☐ No % of revenues: _____
Radius: _____
Separate Lounge: ☐ Yes ☐ No
Twenty-four hour operation: ☐ Yes ☐ No
Number of: Hosts _____ Valet Parkers _____
Waitpersons _____ Bartenders _____
Cooks _____ Take-out: ☐ Yes ☐ No

APARTMENT OWNER OR OPERATOR:

List of operations sub-contracted to others: _____
Current employees perform sub-contracted operations for you? ☐ Yes ☐ No *If yes*, please list: _____
The following items are maintained and kept current for all sub-contractors:
Certificate of workers' compensation insurance ☐ Yes ☐ No
Copy of each sub-contractor's license number ☐ Yes ☐ No

JANITORIAL:

Percentage of revenues from: Office Buildings _____ Manufacturing Plants _____ Medical Properties _____ Other _____
Pressure cleaning? ☐ Yes ☐ No Concrete cleaning or sealing ? ☐ Yes ☐ No Roof or gutter cleanup? ☐ Yes ☐ No
Window Washing requiring ladder or other device for heights ☐ Yes ☐ No Large Debris hauling ☐ Yes ☐ No
Other work requiring ladders ☐ Yes ☐ No
Confined Space (vents, etc) ☐ Yes ☐ No Buffing waxing carpet cleaning ☐ Yes ☐ No
If yes on any of above please explain: _____
_____