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SOCIAL SERVICE WORKERS COMPENSATION SUPPLEMENTAL APPLICATION

APPLICATION INFORMATION

Insured:	Effective Date:	FEIN No.:
Insured Address:		
City:	State:	Zip:
Contact Name & Title:		
Phone:	Fax:	Email:

PAYROLL & PREMIUM HISTORY

	Total Annual Payroll	Premium $
Current Year: 20____________		
Prior Year: 20____________		
Prior Year: 20____________		
Prior Year: 20____________		
Prior Year: 20____________		

GENERAL INFORMATION

Years in business: | Years under current management:

Description of operations:

Number of employees: Full-time ____________ Part-Time ____________ Seasonal ____________ Volunteers ____________

Percent of turnover in last 12 months? Full-time ____________ Part-Time ____________ Volunteers ____________

Is coverage needed for volunteers? ☐ Yes ☐ No

Are medical insurance benefits provided to employees? ☐ Yes ☐ No

If YES, are all employees eligible? ☐ Yes ☐ No If not, who is eligible?

Is personal protective safety equipment provided for all employees as necessary? ☐ Yes ☐ No

Written safety program in place?	☐ Yes	☐ No	Driver's safety program?	☐ Yes	☐ No
Designated safety director?	☐ Yes	☐ No	Regular safety training?	☐ Yes	☐ No
Safety incentive program?	☐ Yes	☐ No	Accident / injury investigation?	☐ Yes	☐ No

Experience Modification Rate (EMR) – current plus prior three years **attach or send worksheet with application**

HIRING PRACTICES

Employment application?	☐ Yes	☐ No	Drug testing?	☐ Yes	☐ No
Reference checks?	☐ Yes	☐ No	Orthopedic back testing?	☐ Yes	☐ No
Pre- / post-employment physicals?	☐ Yes	☐ No			

CLAIMS MANAGEMENT

Designated person to manage workers compensation claims? ☐ Yes ☐ No

If YES, provide name of designated person:

Formal return-to-work / modified light-duty program? ☐ Yes ☐ No

Job descriptions in place for modified light-duty? ☐ Yes ☐ No

Preferred medical provider? ☐ Yes ☐ No

If YES, provide name of preferred clinic, physician, or emergency room:

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INSURANCE INFORMATION
Has the insured had three years of continuous workers compensation coverage? ☐ Yes ☐ No
Has the insured's workers compensation coverage ever been cancelled? ☐ Yes ☐ No If YES, provide reason for cancellation: ☐ Non-payment ☐ Underwriting reasons ☐ Other (please specify): ______
Are all operations of the insured being submitted? ☐ Yes ☐ No

ADDITIONAL INFORMATION
Are any employees under the age of 16? ☐ Yes ☐ No
Do employees perform work for any business not owned or operated by the insured? ☐ Yes ☐ No
Does the applicant own, operate, or lease aircraft used to transport employees in the conduct of the insured's business? ☐ Yes ☐ No
Do five or more employees ever travel together? ☐ Yes ☐ No
Do employees travel overnight? ☐ Yes ☐ No If YES, is any travel to foreign destinations? ☐ Yes ☐ No
What percent of employees' activities is performed off the insured's premises: ☐ 0-15% ☐ 15-25% ☐ 25-50% ☐ More than 50%
Is the risk currently insured in an assigned risk pool or a non-voluntary market? ☐ Yes ☐ No If YES, please describe:
Has the insured had any OSHA violations in the past 36 months? ☐ Yes ☐ No
Are any machines used in the scope of the insured's operations? ☐ Yes ☐ No

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