

# WORKERS' COMP SUPPLEMENTAL APPLICATION

Insured:

Eff. Date:

Contact Name & Title:

Tel. #.:

Fax #.:

Website Address :

**GENERAL INFORMATION:**

Years in business:	# of locations	Past Payroll Info (Annualized Lump Sum per yr or Can send in Exmod Worksheet Instead):			
Description of operations		2017-2018=		2015-2016=	
		2016-2017=		2014-2015=	
Union: Yes No	If yes, name of Union				
Current number of employees:	Full time	Part time	Seasonal	Volunteers	
Percent of employee turnover in the last 12 months	Full time	Part time			
Employee staffing expectation over the next 12 months	Full time	Part time			
Average hourly wage in Governing Class:	Full time \$	Part time \$			
Average hourly wage in Clerical class:	Full time \$	Part time			
Average hourly wage in Sales class:	Full time \$	Part time			
Has the insured ever been in bankruptcy?	Yes No	If yes, explain			

**BENEFITS:**

Are ALL employees eligible Y/N; if no then who?				% paid by employer		% of participation	
Group Health	Yes	No		Yes	No	Retirement / Pension Plan	Yes No
Paid sick leave	Yes	No	Vacation	Yes	No		
Name of Healthcare provider:							
Do you use a specific:	Clinic	Physician	Emergency room				
CPR training provided?	Yes	No					

**SAFETY PROGRAM:**

Safety program / IIPP compliant 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					
Do you have a Health & Wellness program?	Yes	No					
Describe Health & Wellness activities: (eg. physical fitness and nutrition assessment and consultation, lifestyle health risk appraisal, discounted gym membership, walk-at-lunch program, weight loss/smoking cessation program, stress reduction, first aid, blood pressure management, physical demand validation of job descriptions, etc.)							

**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

Hours of operation: to			Number of daily shifts		
Operation includes driving?	Yes	No	Number of authorized drivers	No. of vehicles	
Types of vehicles driven					
Reason(s) for driving (delivery, sales calls, etc.)?					
Frequency of driving:	Daily	Weekly	Other		
Driving radius:					
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	
Motor Carrier Permit (MCP) Filing Number:					
Any travel out of Country/ State?	Yes	No	What Countries and/or States?	No. of employees who travel?	Frequency?