



# Workers Compensation Supplemental Application

Named Insured: \_\_\_\_\_ Eff Date: \_\_\_\_\_

Agency/Brokerage Firm: \_\_\_\_\_ Attn: \_\_\_\_\_ Fax: \_\_\_\_\_

### Employee Benefits:

- A. Medical Insurance: Carrier: \_\_\_\_\_
- Employer pays 80% or more of All Employees
  - Employer pays 50% or more of All Employees
  - Employer pays 49% or less of All Employees
  - Benefits provided only to Management & Supervisors
  - No Medical Benefits provided
- B. Employer paid Vacation? Yes ( ) No ( )
- C. Employer paid Sick Leave? Yes ( ) No ( )

### Employee Management:

- A. Pre-Hire Screening:
- Applications: Yes ( ) No ( )
  - Reference Checks: Yes ( ) No ( )
  - Physical Examinations: Yes ( ) No ( )
- B. Pre-employment Drug Testing Yes ( ) No ( )
- C. Post Accident Drug Testing Yes ( ) No ( )

### Employee Profile:

- A. Union Yes ( ) No ( )
- B. No. of W2's filed for last reporting period: \_\_\_\_\_
- Starting Wage per hour: \$ \_\_\_\_\_
- Average Wage per hour: \$ \_\_\_\_\_
- # Permanent Employees: \_\_\_\_\_ #Full Time \_\_\_\_\_ #Part Time: \_\_\_\_\_
- # of Employees per Class:
- Class: \_\_\_\_\_ # \_\_\_\_\_ Class: \_\_\_\_\_ # \_\_\_\_\_ Class: \_\_\_\_\_ # \_\_\_\_\_
- Class: \_\_\_\_\_ # \_\_\_\_\_
- # Temp/Seasonal Employees: \_\_\_\_\_
- Employee Turnover per year: \_\_\_\_\_
- Average # of years with Company: \_\_\_\_\_
- C. Interchange of labor (if yes, existence of physical separations) \_\_\_\_\_
- 
- D. Percent of payroll for "off premises" operations: \_\_\_\_\_%
- Operations performed off employer's premises: \_\_\_\_\_
- 
- E. No. of Company Autos \_\_\_\_\_ No. of Drivers: \_\_\_\_\_
- No. of Company Trucks \_\_\_\_\_
- Radius of Driving Operations: \_\_\_\_\_ MVR's Checked: Yes ( ) No ( )
- How often are MVR's run: \_\_\_\_\_ per year.
- F. Do Employees drive their personal autos on Company Business: Yes ( ) No ( )
- G. Are Employees allowed to use motorcycles on Company Business: Yes ( ) No ( )
- H. Hours of Operation \_\_\_\_\_
- I. Any weekend, nightshifts or graveyard shifts? Yes ( ) No ( )
- J. Early Return to Work Program? Yes ( ) No ( )
- K. If the risk is a restaurant, do they also operate a micro-brewery? Yes ( ) No ( )

### Employee Safety Program:

- A. New Employee Orientation Plan Yes ( ) No ( )
- B. Formal Written Safety Program Yes ( ) No ( )
- C. Documented Safety meetings with all Employees? Yes ( ) No ( )

- D. Safety Incentive Plan Yes ( ) No ( )
- E. Written Supervisor Accountability Plan Yes ( ) No ( )
- F. Full Time Safety Director/Risk Manager Yes ( ) No ( )
- G. Employee Training Program for all employees? Yes ( ) No ( )
- H. Documented Physical Inspections of premises Yes ( ) No ( )
- I. Maximum weight lifted manually \_\_\_\_\_ lbs  
Controls (back belts, forklifts) \_\_\_\_\_  
List mechanical lifting devices used: \_\_\_\_\_
- J. Machine safety guards in place: Yes ( ) No ( )
- K. Lockout/Tag-out Program in place? Yes ( ) No ( )
- L. Personal Protective Equipment provided and usage enforced? Yes ( ) No ( )
- M. Documented Accident Investigation? Yes ( ) No ( )
- N. Formal Disciplinary Procedure in place? Yes ( ) No ( )

**Employee & Payroll Trends:**

- A. Future Staff Increases: \_\_\_\_\_ Future Staff Decreases: \_\_\_\_\_
- B. Future Layoffs Foreseen: Yes ( ) No ( )

**Management:**

- A. Owners: Active in Management: Yes ( ) No ( )
- B. Trade Associations: \_\_\_\_\_
- C. Group Transportation Provided: Yes ( ) No ( )
- D. Ratio of Supervisors to Employees: \_\_\_\_\_  
Average # of year's experience: \_\_\_\_\_  
Average # of years with Company: \_\_\_\_\_

**Claims:**

Please forward the following 3 year's loss information to us:  
Valuation date should be within 90 days of the policy inception date.

- Current Year
- First Year Prior
- Second Year Prior
- Third Year Prior

For all claims over \$25,000, please advise the following:  
What was the injury?  
How did it occur?  
What corrective action has the insured taken to prevent recurrence?

Please send us a current experience modification worksheet if available

**Insured's Website Address:** \_\_\_\_\_

**Additional Information/Comments:**

\_\_\_\_\_  
\_\_\_\_\_

**Please return this Questionnaire by:** \_\_\_\_\_

**Completed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Title:** \_\_\_\_\_