

WORKERS' COMPENSATION SUPPLEMENTAL APPLICATION

Account Name: _____ Effective Date: _____

Agency: _____ Signature: _____

OPERATIONS:

Hours of operation? _____

How many days per week? _____

How many shifts? _____

Are there any night or graveyard shifts? _____

Is owner active in business? _____

Does the company own any vehicles? _____

If so please describe the vehicle's use _____

Does the insured deliver? _____

If so, what is the radius of delivery? _____

How many drivers? _____

How many deliveries are made per day? _____

What is the percentage of sales from delivery? _____

Have there been any changes in the operations the past 3 years? _____

Is there any out-of state exposure? _____

What is the condition of the premises? _____

What is the condition of the equipment? _____

MANAGEMENT / HIRING PRACTICES:

How many years does the owner/manager have in this trade? _____

How many years does the owner have running this business? _____

Are the following done prior to hiring an employee:

References checked? _____

Drug/Substance Abuse Test? _____

Pre/Post employment physicals? _____

MVR's Checked? _____

Orthopedic back/audio tests? _____

EMPLOYEE SAFETY:

Is there a written safety program (SB 198)? _____

Who is the person responsible for safety? _____

Are safety meetings conducted? _____

Frequency of meetings? _____

Is there a safety incentive program? _____

WORKERS' COMPENSATION SUPPLEMENTAL APPLICATION (Continued)

Is medical insurance provided? _____
If so, what is the name of the group Medical Provider? _____
What is the percentage paid by employer? _____
What is the percentage of employee participation? _____
Does insured use a specific medical provider for injuries? _____
If so is it a Clinic ___ Physician ___ Other _____
Does insured have a return to light duty or full time modified work program? _____
Is the insured willing to implement Safety Recommendations made by the Carrier? _____
Is the insured willing to implement Loss Control Recommendations made by the Carrier? _____

PLEASE PROVIDE PAYROLL FOR PAST 4 YEARS:

2006-07 _____ 2005-06 _____ 2004-05 _____ 2003-04 _____

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

SERVICE STATIONS-MINI MARTS/AUTO REPAIR & BODY SHOPS/TRANSMISSION SHOPS: (No blanks or n/a's please).

Number of service bays. _____
Is tire repair or installation performed? _____
Is any work done on trucks over 1 ton? _____
Is any commercial tire work performed? _____
Is any Split Rim work performed? _____
Does insured perform any Towing Services: Yes ___ No ___
Does the insured provide and Road-Side Service? _____
Is there a Mini Market? _____
If so what are the Hours of Operation? _____
Is a Drop Safe used? ___ Is there a Bullet Proof Cashier Booth? _____
Access to Freeway is within : 0-1 miles ___ 1-2 miles ___ 2+ miles ___
Is there a Car Wash? _____
If so is it Full Service _____ Self-Service _____