Supplemental Application

To be completed with ACORD 130 Application

Named Insured: _____ Web Address: _____

Insured's FEIN: _____

	Contact Name	Phone Number
Inspections:		
Premium Audit:		
Claims:		

PRIOR PAYROLL AND PREMIUM INFORMATION

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

Does applicant currently use a PEO or payroll service? ☐ Yes ☐ No

If yes, provide name of organization used: _____

Broker controlled account? ☐ Yes ☐ No

OPERATIONS AND PREMISES

Please provide a detailed description of the operation:

Years in business? _____ Hours of operation: _____

Has the ownership of the applicable entity changed within the past five years? ☐ Yes ☐ No

If yes, please provide details: _____

Any out-of-state, international, or overnight (within state) travel? ☐ Yes ☐ No

If yes, provide details: _____

Why/Purpose: _____

Who will travel? _____ Where: _____

Duration? _____ Frequency? _____

Any locations in other States (including incidental clerical or sales)? ☐ Yes ☐ No

If yes, provide details: _____

No. of employees who live/work out of state: Live: _____ Work: _____

What is the maximum height in feet you will work? _____ What is used? ☐ Ladder ☐ Scaffolding ☐ Scissor Lifts ☐ Other

If scaffolding used, does the insured build their own? ☐ Yes ☐ No

If insured builds own scaffolding, provide % of annual operations involving scaffold setup and tear down compared to total operations: _____%

Written Fall Protection Program? ☐ Yes ☐ No

Any material handling exposures? ☐ Yes ☐ No

If yes, please explain: _____

Any lifting exposures? ☐ Yes ☐ No If yes, ☐ <25 lbs ☐ 25-40 ☐ 40+

If 40+ lbs, ☐ manual lifting or ☐ with assistance? Explain: _____

Forklift training provided? ☐ Yes ☐ No ☐ N/A If yes, annual certification? ☐ Yes ☐ No

Is all machinery/equipment properly guarded? ☐ Yes ☐ No

Any use of Baler equipment? ☐ Yes ☐ No

Written lockout/tagout/blockout procedures in place? ☐ Yes ☐ No ☐ N/A

Condition of equipment? ☐ New ☐ Good ☐ Average

Age of equipment? ☐ 0-5 years ☐ 5-10 ☐ 10-20 ☐ 20+
Are all equipment operators trained/certified? ☐ Yes ☐ No ☐ N/A
Is the building/premises: ☐ Owned ☐ Leased Condition of premises? ☐ Excellent ☐ Very good ☐ Average
No. of years at current location: _____

VEHICLE AND DRIVING EXPOSURE

Is there a driving or delivery exposure? ☐ Yes ☐ No
If yes, what is the frequency? ☐ Daily ☐ Weekly ☐ Other: _____
No. of vehicles: _____ No. of drivers: _____
Radius of operations/travel: ☐ <10 miles ☐ 11-50 ☐ 50-100 ☐ 100-200 ☐ 200+
Are vehicles company owned? ☐ Yes ☐ No
If yes, types of vehicles: _____
If yes, are company vehicles taken home: ☐ Yes ☐ No
Vehicle/fleet maintenance program? ☐ Yes ☐ No
If yes, who does the servicing? ☐ Outside vendor ☐ In-house mechanics ☐ Other: _____
Any group transportation of employees? ☐ Yes ☐ No If yes, by: ☐ Car ☐ Truck ☐ Van ☐ Bus
No. of vehicles used to transport: _____ No. of employees transported per vehicle: _____
Frequency of group transportation: ☐ Daily ☐ Weekly ☐ Monthly
Do employees use personal vehicles for company business? ☐ Yes ☐ No
Is insured enrolled in DMV Pull program? ☐ Yes ☐ No
Is a PUC/DMV filing required? ☐ Yes ☐ No ☐ N/A *If yes, please attach a copy of the certificate.*
Are driver acceptability standards in place? ☐ Yes ☐ No
If yes, provide details below:

_____

Does insured have and enforce the following policies for drivers:
Alcohol/drug use: ☐ Yes ☐ No Seat belt use: ☐ Yes ☐ No Distracted driving: ☐ Yes ☐ No
Any work-related injuries as a result of a prior motor vehicle accident within the past four years? ☐ Yes ☐ No
If yes, please provide details, including fault of accident and if subrogation was pursued:

HIRING PRACTICES - EMPLOYEE SELECTION

Written application?	☐ Yes ☐ No	Pre-hire drug testing?	☐ Yes ☐ No
Reference checks?	☐ Yes ☐ No	Post-accident drug testing?	☐ Yes ☐ No
Background checks?	☐ Yes ☐ No	Pre/post-employment physicals?	☐ Yes ☐ No
MVR checks?	☐ Yes ☐ No	Orthopedic back testing?	☐ Yes ☐ No
Audio hearing tests?	☐ Yes ☐ No	Formal job descriptions on file?	☐ Yes ☐ No

No. of employees: *(verify number is consistent w/number on ACORD application)*
Full: _____ Part: _____ Seasonal: _____ Volunteers: _____
No. of employees per location: 1. _____ 2. _____ 3. _____ 4. _____
Do any employees work from home? ☐ Yes ☐ No If yes, how many employees? _____
How are employees paid? ☐ Hourly ☐ Piece rate ☐ Commission ☐ Flat Salary ☐ Other: _____
Average hourly wage for employees in the governing class: $_____ Average annual employee turnover_____%
Number of new hires? Past 12 months: _____ Past 13-24 months: _____
Employee to Supervisor ratio: ☐ Better than 4-1 ☐ 5-1 ☐ 6-1 ☐ 7-1 ☐ >7-1
Percent of Union Employees: _____% Percent of Non-Union: _____%
No. of shifts: _____ Does the applicant allow employees to work more than three consecutive 12-hour shifts? ☐ Yes ☐ No
Any interchange of labor? ☐ Yes ☐ No If yes, please explain: ☐ Another Business ☐ Subsidiary ☐ Business Dept. ☐ Other
Any day laborers or temporary/employee leasing? ☐ Yes ☐ No
Subcontractors used? ☐ Yes ☐ No
If yes, for what purpose/operations? _____
If yes, are certificates of insurance obtained and kept on file? ☐ Yes ☐ No
Independent contractors used? ☐ Yes ☐ No If yes, for what purpose? _____
If yes, how are they paid? ☐ 1099 ☐ Other, please explain: _____

BENEFITS

Group medical provided? ☐ Yes ☐ No

If group medical is provided, who is the healthcare provider? _____

Percent of employees enrolled: _____%

Percent paid by employer: _____%

Retirement/pension plan? ☐ Yes ☐ No

Does employer contribute? ☐ Yes ☐ No

Do you have a wellness program (i.e. encourages and promotes employee health programs) in place? ☐ Yes ☐ No

Do you provide paid sick leave? ☐ Yes ☐ No

Paid vacation? ☐ Yes ☐ No

CLAIMS REPORTING AND INVESTIGATION

Are there set procedures for reporting claims? ☐ Yes ☐ No

Average claim reporting time frame: _____

Do you have a formal written accident report? ☐ Yes ☐ No

Are corrective actions taken and safety measures implemented following injuries? ☐ Yes ☐ No

Are supervisors held accountable for injuries/accidents? ☐ Yes ☐ No

Is there a formal Safety Committee? ☐ Yes ☐ No

Return to Work Program (RTW) in place? ☐ Yes ☐ No

Does it include salary continuation? ☐ Yes ☐ No

Do you use a specific medical provider to treat injured employees? ☐ Yes ☐ No

Are you currently participating in a MPN (Medical Provider Network)? ☐ Yes ☐ No

If yes, please provide the name of current MPN: _____

SAFETY PROGRAM AND ORGANIZATION

Are owners active in daily operations? ☐ Yes ☐ No

If yes, are they excluded from coverage? ☐ Yes ☐ No

Active injury & illness prevention program? ☐ Yes ☐ No

Heat illness prevention program? ☐ Yes ☐ No

Active safety incentive program? ☐ Yes ☐ No

If yes, does it encompass all employees? ☐ Yes ☐ No

What type of incentive? _____

Do employees receive safety training/orientation? ☐ Yes ☐ No

If yes, is the training: ☐ Formal/Documented ☐ Informal

Are safety meetings conducted? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Other

Is job specific training provided? ☐ Yes ☐ No

Documented Employee Orientation Program in place? ☐ Yes ☐ No

Do you have a safety director or risk manager? ☐ Yes ☐ No

Name and title: _____

If yes, is the position full time or an additional responsibility of another employee? _____

Personal protection equipment provided? ☐ Yes ☐ No ☐ N/A

If yes, strict enforcement of utilization? ☐ Yes ☐ No

What types of PPE? _____

Written Respiratory program in place? ☐ Yes ☐ No

CPR training provided? ☐ Yes ☐ No

No. of employees certified? _____

Have loss control services been performed in the last year? ☐ Yes ☐ No

Has Cal/OSHA visited/cited your business in the last year? ☐ Yes ☐ No

If yes, please provide details:

MSDS (Material Safety Data Sheets) available for all chemicals and products used? ☐ Yes ☐ No ☐ N/A

This section must be completed by all applicants who are individuals, sole proprietorships, husband and wife, or partnerships (where the general partners are husband and wife).

Please list below any relatives residing in your household who are employees of your business and to whom your books and records show payments to such relatives:

Employed Relatives*			
Name	Relationship to You	Job Title or Duties	Estimated Annual Remuneration

Check here if there are no relatives residing in your household that are employed in your business: ☐

***Relatives are defined as: spouse, child by birth or adoption, stepchild, grandchild, son-in-law, daughter-in-law, parent, step-parent, parent-in-law, grandparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, sister-in-law, uncle, aunt, nephew, or niece.**

Note: Per California Labor Code, as an employer you are required to include in your Workers' Compensation coverage all relatives residing in your household who are your employees. Any policy issued based on information provided in this application will exclude coverage for residing relatives if none are listed above.

Note: All information provided is subject to verification by way of an underwriting survey or inspection. Arrowhead General Insurance Agency, Inc. must be notified of any significant change in operations or payroll. Terms of insurance coverage may be cancelled for misrepresentation if information provided is inaccurate.

Signature of Applicant: _____ Date: _____

HEALTH AND HUMAN SERVICES

Is applicant a licensed facility? ☐ Yes ☐ No If yes, please explain:_____

Is operation accredited by CARF (Commission on Accreditation Rehabilitation Facility)? ☐ Yes ☐ No ☐ N/A

Total Number of Beds: _____ Number of Beds Currently Occupied:_____

Percentage of private paying patients: _____% Percentage of Medicare/Medicaid patients:_____%

Percentage of residents/patients that are Ambulatory _____**%** ***(move about facility on their own with use of cane, walker or motorized scooter)***

Percentage of residents/patients that are Non-Ambulatory _____**%** ***(bed or wheelchair-ridden; require assistance to get in/out of bed/wheelchair)***

Is group transportation of clients/patients provided? ☐ Yes ☐ No

If yes, number of company vehicles used for group transport?_____

If yes, number of personal vehicles used for group transport?_____

Is group transportation sub-contracted to third party? ☐ Yes ☐ No

Any off-site activities? ☐ Yes ☐ No If yes, provide details:_____

Does applicant conduct home safety inspections prior to contracting with client for in-home patient services? ☐ Yes ☐ No

If yes, are acceptability standards established? ☐ Yes ☐ No

Does applicant offer "live-in" employees at client's residence/premises? ☐ Yes ☐ No

If yes, what percentage?_____

Does applicant employ relatives of their clients? ☐ Yes ☐ No

If yes, provide number of family related employees employed:_____

Provide the typical relationship of employees to client (i.e. daughter, son, brother, sister, mother, father, etc.):_____

Are relative employees held to the same hiring practices and training standards as all other employees? ☐ Yes ☐ No

Are remuneration/compensation packages the same for "relative employees" as for "non-relative employees"? ☐ Yes ☐ No

If no, provide details:_____

Does applicant have formal protocols in place that comply with CDC/OSHA regulations on pandemic control and prevention – including Coronavirus? ☐ Yes ☐ No

Does risk have a written Blood borne Pathogen Program? ☐ Yes ☐ No

Does applicant treat for communicable diseases (i.e. HIV, AIDS, etc.)? ☐ Yes ☐ No ☐ N/A

Does risk have patient/resident handling/lifting equipment? ☐ Yes ☐ No

Does risk have written patient/resident handling protocols? ☐ Yes ☐ No

Are employees required to wear slip-resistant shoes? ☐ Yes ☐ No

Does risk provide ongoing In-Service Training? ☐ Yes ☐ No If yes, how often?_____

Does risk provide food service? ☐ Yes ☐ No If yes, please provide details: _____

Does risk have volunteers? ☐ Yes ☐ No If yes, is separate policy in place to cover volunteers? ☐ Yes ☐ No

If yes, provide details (# of volunteers, duties performed, etc.):_____

Indicate percentage of operations in each of the following categories or mark not applicable - ☐ N/A												
Abortion Clinic:		%	**Acupuncture/Acupressure:**		%	**Blood Banks/Donor Clinic:**		%	**Drug/Alcohol Treatment Clinic:**		%
Family Practice:		%	**Hospice:**		%	**Industrial Clinic:**		%	**Med Lab/Testing:**		%
Mobile Operation:		%	**Specialist:**		%	**Urgent Care Clinic:**		%	**Walk-in Clinic:**		%
Weight Control Clinic:		%	**Other:**								%
Indicate percentage of operations in each of the following categories or mark not applicable - ☐ N/A												
Physicians/MD:		%	**PhD:**		%	**Psychiatrist:**		%	**Psychologist:**		%
Physicians Asst.:		%	**Nurse Practitioner:**		%	**Registered Nurse:**		%	**Licensed Voc. Nurse:**		%
Cert. Nurses Asst.:		%	**Social Worker:**		%	**Counselor:**		%	**Dietary:**		%
Dentists/Surgeons:		%	**Registered Dental Asst.:**		%	**Dental Hygienist:**		%	**Chiropractor:**		%
Physical Therapist:		%	**Physiotherapist:**		%	**Occupational Therapist:**		%	**Administrative:**		%

Does insured require employees to take specific health care-related classroom or online classes which would give them a certificate or certification after passing? ☐ Yes ☐ No

What percentage of total employees?_____% If yes, provide details regarding the type of certification:_____

If organization is a day care center or provides day care operations indicate the percentage below:

Children age up to 1yr:_____**% 1-3yrs**_____**% 3-5yrs**_____**%**

Maximum enrollment:_____ **Number of currently enrolled children:**_____

Is organization an adult day care? ☐ Yes ☐ No Maximum enrollment:_____

If facility is a day care center for children or adults, provide ratio of staff member to child/adult: ☐ 1 to 2 ☐ 1 to 3 ☐ 1 to 4 ☐ Other

Is the operation based out of a home residence? ☐ Yes ☐ No

If operation provides veterinary services please provide percentage below:

Domestic/Household pets:_____% Farm animals:_____% Exotic/Wild:_____%

Provide details:_____

Provide percentage of the following: Grooming:_____% Kennel:_____% Boarding:_____%

Any field or off-site services provided? ☐ Yes ☐ No

If yes, provide details:_____