

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: _____

PEST CONTROL

Types of operations:

- Commercial Agricultural Residential Industrial Structural Structural repairs or replacements Dry rot wood repair
 Shower pan replacement Chemical treatment services Fumigation Foam
 Other: Provide details: _____

Percentage of tenting: ____% N/A

Lawn treatment care: Yes No If yes, provide details: _____

Other services? Provide details below:

Check each of the applicable services available:							
Ants	Spiders	Roaches	Fleas	Ticks	Wasps	Mosquitoes	Bees
Killer Bees	Bee removal	Mice	Termites	Rats	Snakes	Raccoons	Opossums
Bird/pigeon control		Animal removal		Animal trapping		Bird/rodent proofing	
Rodents	Gophers	Skunks	Bats	Other:			

Personal protective equipment required: _____

- Written injury program? Yes No Written haz-com program? Yes No
 Written heat stress program? Yes No Written respiratory protection program? Yes No
 Special written procedures for working in confined spaces (attics, under residences or buildings)? Yes No
 Documented new employee orientation including documented training? Yes No