Supplemental WC Application – Health Care

Instructions:
• Please type or print clearly in ink. All sections must be completed fully.
• If you need more space, attach additional sheets as needed using company letterhead

1. APPLICANT OVERVIEW

Firm Name:

_____

(If the insured has a DBA please list)

Date business established: _____ Number of years under current ownership: _____

Website URL is: www._____

a) Are medical/health insurance benefits provided to employees? ☐ Yes ☐ No
b) Are more than 75 employees located at any one location at any one time _____ ☐ Yes ☐ No
c) Indicate annual turnover rate: _____%
d) Do any employees work longer than a 12 hour shift? ☐ Yes ☐ No
If yes, please provide details:_____
e) Indicate percentage of volunteers in the workforce: ☐ 0% ☐ 1 – 10% ☐ 11 – 40% ☐ > 40%

Business Operations (check all that apply)

☐ Home Health - Skilled Nursing	☐ Substance Abuse Counseling	☐ Nursing Home
☐ Personal Care Provider	☐ Mental Health Counseling	☐ Assisted Living
☐ Hospice Provider	☐ Crisis Response Team	☐ Community Hospital
☐ Physical Therapy / Occ. Health	☐ Drug Treatment / Detox	☐ Clinic

Please indicate where your employees perform their work:

☐ Private Homes/Apt. _____%	☐ Clinics _____%	☐ Nursing Homes _____%
☐ Doctor's offices _____%	☐ Hospitals _____%	☐ Corporate offices _____%
☐ Day Care Setting _____%	☐ Community Residences _____%	☐ Other Locations _____%

Please specify if other:

_____

_____

2. RISK MANAGEMENT AND SAFETY PROGRAMS

a) What is the average radius that employees drive during the workday? _____ miles
b) Do more than 3 employees travel together in any one vehicle? ☐ Yes ☐ No
c) Are MVRs checked annually for all employees who drive as part of their job? ☐ Yes ☐ No
d) What standard are traveling employees held to regarding MVRs: ☐ No violations in the last 3 years and/or ☐ No more than _____ violations in the last 3 years.
e) Is a formal safety program in place? ☐ Yes ☐ No
f) Indicate the following safety practices the applicant has in place:

☐ Driver Safety Programs	☐ Accident/Injury Investigation	☐ New Employee Orientation
☐ Safety Committee	☐ Patient Handling/Transfer Training	☐ Blood Borne Pathogen
☐ Safety Incentive Program	☐ Performance Evaluations include safety	☐ Combative Patient Training
☐ Regular Formal Safety Training Conducted		

☐ Management involvement in safety (describe below if checked)

_____

_____

Hiring Practices:

Check the following boxes to indicate screening measures that are applied to prospective employees (note: some are post offer)

☐ Reference Check	☐ Validate Work History	☐ Personal Interviews
☐ Drug Testing/Screening	☐ Criminal Background Check	☐ Verification of Certifications/licenses
☐ Post-Offer Physicals	☐ Child Abuse Clearance	☐ Psychological Testing

Claims Management:

a) Is there a designated person to manage workers' compensation claims?	☐ Yes	☐ No
b) Is there a formal Return to Work/Modified Duty Program in place?	☐ Yes	☐ No
c) Have detailed light duty job descriptions been developed?	☐ Yes	☐ No
d) Has a relationship been established with a preferred medical provider?	☐ Yes	☐ No

3. INSURANCE INFORMATION

a) Has the applicant had continuous WC coverage for the past 2 years?	☐ Yes	☐ No
b) Has the applicant's WC insurance been cancelled for nonpayment within the last 3 years?	☐ Yes	☐ No
c) Has the applicant's WC ever been cancelled for Underwriting Reasons?	☐ Yes	☐ No
If Yes, what is the reason _____		
d) Is the applicant's current WC insurance provided through an Assigned Risk Plan?	☐ Yes	☐ No
e) Does the applicant supply any workers to other employers on a temporary or permanent basis?	☐ Yes	☐ No
f) Are all the applicant's operations (exclusive of monopolistic states) being submitted for WC?	☐ Yes	☐ No

To the best of my knowledge all the information I have given about my business is true and correct. If information is found to be different as the result of my knowingly attempting to defraud the insurance company, or information is concealed for the purpose of misleading, or another person files an application for insurance containing materially false information the insurance company may send direct notice of cancellation.

_____ _____

Applicant Signature Date

_____ _____

Agent Signature Date