



WORKERS' COMPENSATION APPLICATION

Proposed Effective Date _____

Legal Named Insured (full name of all companies to be insured under this policy)

DBA _____

Entity is: S Corp C Corp Individual Partnership Limited Partnership LLC Other

If other, please describe: _____

Website _____

Mailing Address _____

City _____ State _____ ZIP _____ County _____

Physical Address _____

City _____ State _____ ZIP _____ County _____

Contact Person _____ Email _____

Phone No. _____ Fax No. _____

FEIN _____ Medicare Provider No. _____

NPI No. _____ Unemployment No. _____

VGM MEMBER No. _____ OPGA/POINT MEMBER No. _____ AAHOMECARE MEMBER No. _____

I would also like to receive a competitive quote for the following:

- Property Workers' Compensation Cyber/Data Breach Business Auto
 Flood Earthquake Inland Marine Employment Practices Liability

Requested Coverages & Limits

Liability Limit: \$100K/\$500K/\$100K \$500K/\$500K/\$500K \$1 Mil/\$1 Mil/\$1 Mil

*If Excess limits are desired, underlying auto limits are required to be \$1,000,000

Do officers want to be included in Workers' Compensation insurance? Yes No

Owner/Officer Information

Owner/Officer Name	Title/Relationship	Percent of Ownership	Duties	Annual Payroll

Employee Class Code Breakdown

Location _____

Class Code*	Job Description	Estimated Annual Payroll	No. Full-time Employees	No. Part-time Employees
8810	Clerical Office Employees			
8742	Salespersons or Collectors - Outside			
8832	Physician & Clerical			
7380	Drivers, Chauffeurs, Messengers, and Their Helpers - Commercial			
8017	Store: Retail			
8835**	Home, Public, and Traveling Healthcare – All Employees			
8010	Store: Hardware			
4693	Pharmaceutical or Surgical Goods Mfg.			
3724	Electrical Apparatus Installation or Repair & Drivers			
8018	Store: Wholesale			
8833	Hospital Professional Employees			
8871	Clerical Telecommuter Employees			
8045	Store: Drug Retail			

**Additional questions required

If the above class codes are not applicable to your state, the codes will be revised by our office accordingly.

Do you have additional locations? Yes No

If yes, please complete the table below.

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8832	Physician & Clerical			
7380	Drivers, Chauffeurs, Messengers, and Their Helpers - Commercial			
8017	Store: Retail			
8835**	Home, Public, and Traveling Healthcare – All Employees			

8010	Store: Hardware			
4693	Pharmaceutical or Surgical Goods Mfg.			
3724	Machinery or Equipment Erection or Repair			
8018	Store: Wholesale			
8833	Hospital Professional Employees			
8871	Clerical Telecommuter Employees			
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****Additional questions required**

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**Additional questions required

Historical Insurance Information

Current Carrier(s) and Premium _____

What is your current experience modification number? _____

Please attach your experience modification worksheet (page in your current policy).

Have you had any Workers' Compensation claims in the past five years? Yes No

*If yes, please provide a copy of your loss runs for the past five years.

Has your coverage been canceled/non-renewed in the past three years? Yes No N/A

(Respond only if state law permits)

If yes, please explain _____

Exposure Information

Does your company use subcontractors? Yes No

If subcontractors are used, you are required to obtain and file certificates of insurance from each subcontractor.

Does your company provide employee health plans? Yes No

Does your company engage in the operations of leasing employees? Yes No

Does your company have past, present, or discontinued operations involving storing, treating, discharging, applying, disposing, or transporting hazardous material? Yes No

Does your company own, operate, or lease aircraft or watercraft? Yes No

Does your company have a formal safety program? Yes No

If yes, who is responsible for managing the program? _____

If yes, is the training Formal/Documented Informal Other _____

Does your company have a formal return to work program? Yes No

If yes, does it include salary continuation? Yes No

Do your employees receive a safety training orientation? Yes No

Do your employees drive out of state? Yes No

What is the maximum radius of operations? _____ miles

How many drivers do you employ? _____

How many automobiles does the company own (not including trailers)? _____

What is the maximum weight manually lifted? _____ lbs.

If greater than 40 lbs., what types of supplemental lifting devices are used? _____

****Only complete the section below if Home Health Exposure (Class 8835) is present:**

Number of shifts? _____

Does your company ever allow employees to work more than three consecutive 12-hour shifts? Yes No

What are your hours of operation? _____

Is your company affiliated with a franchise? Yes No

If yes, what franchise? _____

What types of services are provided? _____

Does your company have any volunteer workers? Yes No

If yes, how many? _____

Do any of your employees work from home? Yes No

What percentage of patients are bedridden? _____%

What is the turnover rate of employees? _____%

Is a PUC/DMV filing required? PUC DMV N/A

Are vehicles company-owned? Yes No

If yes, types of vehicles? _____

Are vehicles taken home? Yes No

Number of vehicles? _____ Number of drivers? _____

Does your company have a vehicle/fleet maintenance program? Yes No

If yes, who does the servicing? Outside vendor In-house mechanics Other _____

Do you check MVRs at the time of hire? Yes No

Do employees use personal vehicles for company business? Yes No

Does your company provide group transportation for employees? Yes No

If yes, how provided? Car Truck Van Bus

If yes, number of employees transported per vehicle? _____

Do you check MVRs periodically? Yes No

If yes, how often? _____

Do you have a written plan to deal with employees who have poor driving records? Yes No

Do your employees transport patients? Yes No

If yes, how often? _____

Do your employees deliver to patients' homes? Yes No

If yes, how often? _____

Does your company have any out of state, international, or overnight (within state) travel? Yes No

If yes, please provide details –

Why/purpose? _____

Who will travel? _____

Where? _____

Duration? _____

Frequency? _____

Please list the number of employees who live or work out of state:

Live _____ Work _____

What is the average number of patients seen per day, per employee? _____

Are all employees given combative patient training? Yes No

Is slip resistant footwear provided and enforced? Yes No

Are employees trained in the following? (Check all that apply)

Proper Lifting Techniques Passenger Assistance Defensive Driving Techniques None of the above

How are employees paid? Hourly Piece rate Commission Flat salary

Please provide the number of W-2s issued in the last year? _____

Percentage of union employees _____% Percentage of non-union employees _____%

Does your company provide paid sick leave? Yes No

Does your company provide paid vacation? Yes No

Does your company provide a retirement/pension plan? Yes No

If yes, does your company contribute? Yes No

Does your company provide group medical? Yes No

If yes, please name the healthcare provider _____

If yes, please provide the percentage of employees enrolled _____%

If yes, please provide the percentage paid by your company _____%

Does your company provide paid sick leave? Yes No

Does your company use a specific medical provider to treat insured employees? Yes No

Does your company currently participate in a MPN (Medical Provider Network)? Yes No

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

Does your company provide CPR training? Yes No

If yes, please provide the number of employees certified _____

Please provide the actual hourly wage for employees in governing class \$ _____/hour

Does your company use written applications? Yes No

Does your company do reference checks? Yes No

Does your company do pre-hire drug testing? Yes No

Does your company do post-accident drug testing? Yes No

Does your company do pre/post-employment physicals? Yes No

Does your company do orthopedic back testing? Yes No

Does your company do audio hearing tests? Yes No

Does your company have formal job descriptions on file? Yes No

Does your company document pre-existing injuries in personnel files? Yes No

Does your company have a formal written accident report? Yes No

Does your company have a set procedure for reporting claims? Yes No

Please provide the average claim reporting time frame _____

Does your company provide job specific training? Yes No

Does your company have an employee orientation program? Yes No

If yes, is the orientation Verbal only? Verbal and documented?

Does your company have any interchange of labor? Yes No

If yes, please explain Another business Subsidiary Between departments Other _____

Please provide your company's employee to supervisor ratio. Better than 4-1 5-1 6-1 7-1 >7-1

Does your company use independent contractors? Yes No

If yes, for what purpose? _____

If yes, how are they paid? 1099s Other _____

Are your company owners active in daily operations? Yes No

Does your company have an active safety incentive program? Yes No

If yes, does it encompass all employees? Yes No

If yes, for what type of incentive? _____

Has your company had loss control services performed in the last year? Yes No

Has your company had Cal/OSHA visit in the last year? Yes No

If yes, please provide explanation in a separate document.

Does your company conduct safety meetings? Yes No

Does your company have a safety director or risk manager? Yes No

If yes, please provide their name and title _____

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

Does your company have MSDS available for all chemicals and products used? Yes No N/A

Does your company have any material handling exposures? Yes No

If yes, please explain _____

Does your company provide forklift training? Yes No

If yes, does your company have annual certification? Yes No

Does your company have all machinery/equipment properly guarded? Yes No N/A

Does your company have any use of Baler equipment? Yes No

Does your company have written lock out/tag out/block out procedures in place? Yes No N/A

Does your company have a respiratory program in place? Yes No N/A

Please provide the condition of your company's equipment New Good Average

Does your company train/certify all equipment operators? Yes No N/A

Does your company provide personal protective equipment (PPE)? Yes No

If yes, does your company have strict enforcement of utilization? Yes No

Please list the types of PPE your company provides _____

Please provide your company's maximum height at which your employees work _____

Please provide the type of lift used Ladder Scaffolding Scissor lifts N/A

If scaffolding is used, does your company build their own? Yes No

Please provide the number of years your company has been at its current location _____

Please provide the age of your company's occupied building _____

Is your company's building/premises Owned Leased

Please provide the condition of your company's building/premises Excellent Very good Average

Is your company a licensed facility? Yes No

If yes, please explain _____

Is your company accredited by CARF (Commission on Accreditation of Rehabilitation Facilities)? Yes No

Does your company have a written blood born pathogen program? Yes No

Does your company treat HIV and/or AIDS? Yes No

Does your company have patient/resident handling or lifting equipment? Yes No

Does your company have written patient/resident handling protocols? Yes No

Does your company provide ongoing in-service training? Yes No

If yes, how often? _____

Does your company provide food service? Yes No

If yes, please explain _____

Percentage of ambulatory residents/patients _____% Percentage of non-ambulatory residents/patients _____%

Please indicate the percentage of operations in each of the following categories or mark not applicable N/A

Abortion Clinic _____% Acupuncture/Acupressure _____% Blood Bank/Donor Clinic _____%

Drug/Alcohol Rehabilitation Treatment Clinic _____% Family Practice _____% Industrial Clinic _____%

Med Lab/Testing _____% Specialist _____% Mobile Operations _____% Urgent Care Clinic _____%

Walk-In Clinic _____% Weight Control Clinic _____%

Please indicate the percentage of staff in each of the following categories or mark not applicable N/A

Physician/MD _____% PhD _____% Psychiatrist _____% Psychologist _____%

Physician's Asst. _____% Nurse Practitioner _____% RN _____% Licensed Voc. Nurse _____%

CNA _____% Social Worker _____% Counselor _____% Dietary _____% Dentist/Surgeon _____%

Registered Dental Asst. _____% Dental Hygienist _____% Chiropractor _____% Physical

Therapist _____% Physiotherapist _____% Occupational Therapist _____% Administrative _____%

FRAUD WARNING

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY, INCLUDING READING AND EXECUTION OF THE WARRANTY AND FRAUD STATEMENTS CONTAINED BELOW.

Applicant's warranty statement: The undersigned states, represents and warrants that, to the best of his/her knowledge and belief and upon reasonable inquiry, the particulars and Statements set forth and the information contained in documents, if any, attached to this Application are true and accurate and agree that such particulars, statements and information are material to the acceptance of any risk assumed by the Company. The undersigned further declares and agrees that, if any claim, incident or event taking place prior to the effective date of any insurance applied for pursuant to this Application may render inaccurate, untrue or incomplete any statement, particular, or information contained in or attached to the Application, he or she will, as a condition to the effectiveness of any insurance issued pursuant to this Application, immediately report such in writing to the Company, and the Company may in its sole discretion withdraw or modify any outstanding quotations, proposed terms and/or any authorization or agreement to bind the insurance. The signing of the Application does not bind the applicant to purchase the insurance, nor does the review of the Application by the Company bind the Company to issue a policy. It is understood that the Company is relying on the Application and all attachments thereto in the event the policy is used. It is agreed that this Application, including any attachments thereto and material submitted therewith, shall be the basis for the issuance of any policy as to which this Application applies and the Application and any attachments thereto may be attached to and become a part of the policy issued.

Any person who knowingly and with intent to defraud any insurance company or other entity or person submits an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material to the Application, statement of claim or any other submission, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SPECIFIC STATE FRAUD WARNINGS:

PLEASE CAREFULLY REVIEW THE BELOW WARNING THAT IS APPLICABLE TO THE APPLICANT

APPLICABLE IN CT, GA, HI, IL, IA, MA, MI, MS, MO, MT, NE, NV, NC, ND, SC, SD, VT, WI & WY: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit with the intent to defraud or deceive any insurer is guilty of a crime and may be subject to criminal and civil penalties and denial of insurance benefits

APPLICABLE IN ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof. Workers Compensation: Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining workers compensation benefits for himself or herself or any other person is guilty of a Class C felony.

APPLICABLE IN ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

APPLICABLE IN ARIZONA: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

APPLICABLE IN ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN CALIFORNIA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

APPLICABLE IN FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

APPLICABLE IN IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

APPLICABLE IN INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

APPLICABLE IN KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

APPLICABLE IN LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

APPLICABLE IN MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN MINNESOTA: A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.

APPLICABLE IN NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

APPLICABLE IN NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

APPLICABLE IN NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

APPLICABLE IN NEW YORK: GENERAL: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

APPLICABLE IN OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

APPLICABLE IN PENNSYLVANIA: GENERAL: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICABLE IN RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

APPLICABLE IN TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

APPLICABLE IN WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

APPLICABLE IN WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The above has been read and understood by the Applicant.

SIGNATURE OF APPLICANT: _____

(Must be signed by a principal, partner or officer of the Applicant who is duly authorized to execute this Application on behalf of and as binding on the Applicant)