

Workers' Compensation Supplemental Application

(To be completed with an Acord 130 application)

Named Insured: _____		Website: _____	
Insured's FEIN: _____		Proposed Effective Date: _____	
Contact Information			
Inspections: _____	Phone # _____	E-mail: _____	
Claims: _____	Phone # _____	E-mail: _____	
Premium Audit: _____	Phone # _____	E-mail: _____	
Payroll and Premium Information			
Year	Total Annual Payroll	Premium	
Current Year: <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	
Prior Year: <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	
Prior Year: <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	
Prior Year: <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	
Prior Year: <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>	
Operations			
Provide a brief description of the operation(s): _____			

Years in business: _____	Hours of operation: _____ to _____	Number of shifts: _____	
# of employees: Full time _____ Part time _____ Seasonal _____ Volunteers _____ (Verify number is consistent with the Acord app)			
Total number of employee's per location, per shift? _____		How are employees paid? <input type="checkbox"/> Hourly	
Number of W-2's issued - Last year: _____ Previous year: _____		<input type="checkbox"/> Piece Rate <input type="checkbox"/> Commission <input type="checkbox"/> Flat Salary	
Any day laborers or temporary employee leasing? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details on a separate page.		<input type="checkbox"/> Other: _____	
Percent of union employees _____ %		Is there a firearm on the premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there a driving / delivery exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No		Radius of operations / travel: <input type="checkbox"/> < 50 mi. <input type="checkbox"/> 50 - 100 <input type="checkbox"/> 100+	
If yes, what is the frequency? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other: _____			
Are any vehicles company owned? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are vehicles taken home? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of vehicles? _____ Number of drivers? _____		Any group transportation of employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how provided? <input type="checkbox"/> Car <input type="checkbox"/> Truck <input type="checkbox"/> Van <input type="checkbox"/> Bus Number of employees transported per vehicle: _____	
Any personal vehicles used for company business? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of vehicles used to transport: _____	
Is a PUC/DMV filing required? <input type="checkbox"/> PUC <input type="checkbox"/> DMV <input type="checkbox"/> N/A		Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	
Vehicle / Fleet Maintenance Program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who does the servicing? <input type="checkbox"/> Outside Vendor <input type="checkbox"/> In-house Mechanics <input type="checkbox"/> Other: _____			

Do any employees work from home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain? _____	
List the number of employees who live or work out of state: Live: _____ Work: _____	
Any out of state, international, or overnight (within state) travel? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details: _____ Why / Purpose: _____ Who will travel: _____ Where: _____ Duration: _____ Frequency: _____	
Group medical provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of health care provider: _____	
Percent of employees enrolled: _____ % Percent paid by employer: _____ %	
Do you use a specific medical provider to treat injured employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently participating in a MPN (Medical Provider Network)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name of the current MPN: _____	
Retirement / Pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Paid sick leave? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the employer contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No	Paid vacation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is CPR training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many employees are certified? _____	Is a RTW (Return to Work) Program offered ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does it include salary continuation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the ownership of the applicable entity changed within the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details: _____	
Is the building / premises - <input type="checkbox"/> Owned or <input type="checkbox"/> Leased Condition of premises? <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Average	
Number of years at current location? _____ year(s) Age of building occupied? _____ year(s)	
Hiring Practices and Procedures	
Written Application? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pre-Hire drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reference Checks? <input type="checkbox"/> Yes <input type="checkbox"/> No	Post Accident drug testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pro/post employment physicals? <input type="checkbox"/> Yes <input type="checkbox"/> No	MVR Checks? <input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic back testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Audio hearing tests? <input type="checkbox"/> Yes <input type="checkbox"/> No
Formal job descriptions on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any Interchange of Labor? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are personnel files documented for pre-existing injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please explain: <input type="checkbox"/> Another business <input type="checkbox"/> Subsidiary <input type="checkbox"/> Between departments <input type="checkbox"/> Other: _____
Do you have a formal written accident report? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is job specific training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee Orientation Program? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the orientation <input type="checkbox"/> Verbal Only <input type="checkbox"/> Verbal and Documented	
Employee to Supervisor ratio - <input type="checkbox"/> Better than 4-1 <input type="checkbox"/> 5-1 <input type="checkbox"/> 6-1 <input type="checkbox"/> 7-1 <input type="checkbox"/> >7-1	
Subcontractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what purpose? _____ If yes, are certificates of insurance obtained and kept on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Independent Contractors used? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for what purpose? _____ If yes, how are they paid? <input type="checkbox"/> 1099's <input type="checkbox"/> Other? Please explain- _____	

Safety Program and Procedures

Are owners active in the daily operations? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, are they excluded from coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Active Injury & Illness prevention program? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has loss control services been performed in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Active safety incentive program? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has Cal/OSHA visited/cited your business in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, does it encompass all employees? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please provide an explanation on a separate page	
What type of incentive? _____		Are safety meetings conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do employees receive safety training/orientation? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	
If yes, is the training: <input type="checkbox"/> Formal/Documented <input type="checkbox"/> Informal		<input type="checkbox"/> Quarterly <input type="checkbox"/> Other: _____	
Do you have a safety director or risk manager? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and Title: _____	
If yes, is the position full time or an additional responsibility of another employee? _____			
Are there set procedures for reporting claims? <input type="checkbox"/> Yes <input type="checkbox"/> No		Estimated time frame for reporting a claim: _____	
MSDS (Material Safety Data Sheets) available for all chemicals and products used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A			
Any material handling exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain _____	
Forklift training provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		If yes, annual certification? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Any lifting exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, <input type="checkbox"/> < 25 lbs. <input type="checkbox"/> 25 - 40 lbs. <input type="checkbox"/> 40+ lbs.	
If 40+, manual lifting or with assistance? Please explain: _____			
Is all machinery/equipment properly guarded? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Any use of Baler equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Written lock out/tag out/block out procedures in place? <input type="checkbox"/> Yes <input type="checkbox"/> No		Condition of the equipment? <input type="checkbox"/> New <input type="checkbox"/> Good <input type="checkbox"/> Average	
Respiratory program in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Are all equipment operators trained/certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the maximum height at which you will work? _____		Personal Protection Equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is used? <input type="checkbox"/> Ladder <input type="checkbox"/> Scaffolding <input type="checkbox"/> Scissor Lifts <input type="checkbox"/> N/A		If yes, strict enforcement of utilization? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If scaffolding used, does the insured build their own? <input type="checkbox"/> Yes <input type="checkbox"/> No		What types of PPE? _____	

Contractors

Contractors License Number: _____		Type of License: _____		Years of experience in trade? _____
Estimated annual gross sales? \$ _____		Estimated number of jobs per year? _____		
Percentage of work sub-contracted out? _____ % Type of sub-contracted work? _____				
If sub-contractors used, does insured: <input type="checkbox"/> Check Annually <input type="checkbox"/> Directly supervise sub-contractors				
Average number of certificates collected annually? _____		Average number of Waivers of Subrogation needed? _____		
Indicate the percentage of work constructed in each of the following operations (MUST EQUAL 100 % FOR EACH)				
1) New Construction: _____		Remodeling: _____		Service/Repair: _____
2) Commercial: _____		Apts/Condos/Tract Homes: _____		Single Custom Homes: _____
3) Interior: _____		Exterior: _____		If exterior work done, what is the max. height exposure? _____
Any use of cranes, booms, or similar heavy construction equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Any work below grade? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Max. depth in feet? _____ Percentage of total work: _____ %				
Any confined spaces exposures? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details on a separate page - include a copy of your written procedures and details of Confined Spaces Training.				
Any work involving asbestos, hazardous product abatement, chemical / petroleum products, USL & H, underground tank or pipe replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____				
Does this risk conduct work for the government or city municipality? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is the applicant involved in "Wrap Up" or "OCIP" projects? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the percentage of total payroll dedicated to these projects, and advise detailed procedures on how applicant determines employee split between these projects and other contracts / projects not involving "Wrap Up" or "OCIP".				
Indicate the percentage of work conducted in each of the following operations OR mark not applicable: <input type="checkbox"/> N/A				
Blasting _____	Drilling _____	Light Pole Work _____	Demolition _____	Tunneling _____
Grading _____	Wrecking _____	Roofing _____	Gas Mains _____	Crane Work _____
Asbestos _____	Highway Work _____	Scaffold Set-up _____	Dock/Sea Walls _____	Concrete Tilt-up _____
Sewer _____	Exterior/Framing _____	Structural Steel _____	Bridge Work _____	Excavation _____
Supervisory Only _____	Street/road work _____	Spray Painting _____	Multi-story buildings _____	

Note: All information provided is subject to verification by way of an underwriting survey or inspection. Blue River Underwriters (A Division of Breckenridge Insurance Group) 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:[illegible]