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 time? ___ Yes ___ No
If yes, how many? _____
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 preform their work:

___ Private Homes / Apt. ___%	___ Clinics ___%	___ Nursing Homes ___%
___ Doctor's Office ___%	___ Hospitals ___%	___ Corporate Offices ____%
___ Day Care Setting ___%	___ Community Residences ___%	___ Other Locations ___%

Please Specify 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 MVR's checked annually for all employees who drive as part of their job? ___ Yes ___ No
d) What standard are traveling employees held to regarding MVR's:
___ 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 the 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